PUBLIC HEARING

JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, September 20, 1989

PUBLIC HEARING

BY

JOINT LEGISLATIVE COMMITTEE ON AGING

Columbia, SC - September 20, 1989

Representative Patrick B. Harris, Chairman

Joint Legislative Committee on Aging
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The 27th Annual Public Hearing of the Joint Legislative Committee on Aging was held September 20, 1989 in Room 101, Blatt Building, Columbia, S.C.

The hearing began at 10:30 a.m., recessed for lunch from 12:30 - 1:30, and adjourned at 4:35 p.m.

Members present were: Representative Patrick B. Harris, Chair; Representative Dave C. Waldrop, Vice-Chair; Representative Dill Blackwell; Senator Peden B. McLeod; Senator Isadore E. Lourie; Gloria H. Sholin; Thomas D. Stilwell; and Robert C. Wasson. Senator Nell W. Smith was absent.

Staff members present were: Keller H. Barron, Research Director; Sherri L. Craft, Research Assistant; Beth Mitchell, Administrative Specialist; Catherine Drennon, Legislative Intern and Carolyn Schmitt, Volunteer.

40 persons presented oral testimony, 5 persons submitted written testimony and 142 persons attended the hearing.

OPENING REMARKS:

Good Morning! I'm Pat Harris, Chairman of the Committee. Most of you know them I think, but I would like to introduce the members of the Committee. First we have the Vice-Chairman, Representative Dave Waldrop on my left, Representative Dill Blackwell on my right, Senator Isadore Lourie, Senator Peden McLeod, Gloria Sholin, Thomas Stilwell, and Robert Wasson.

Our staff members are Keller Barron, Sherri Craft, Beth Mitchell, Administrative Specialist, Catherine Drennon, Legislative Intern from USC College of Social Work, and Carolyn Schmitt, volunteer, who always comes in graciously and handles our sign-in table. We are very thankful for this.

I'd like to recognize at this time Shirley Cline from the Life Enrichment Center for Older Adults from Greenville Technical Center. Is she here? If not, when they come in we will see that they are properly introduced. A representative for Congresswoman Liz Patterson from the 4th Congressional district is scheduled to be here and will probably show-up later.

As I said if you will notice we have a full schedule so we are trying to keep it on time as much as we possibly can.

We have some representatives from the media. From my hometown newspaper, we have Jason Goodson from the Anderson Independent and also a representative from Educational Radio Network, Derek Myers. We are glad to have both of you with us and hope you enjoy and learn something from the proceedings.

Lourie - I just wanted to advise you that I am going to leave at 11 and I'll be back around 12 o'clock.

Harris - Senator Lourie has been an integral part of this Committee ever since I've been on it and always contributes much to the work of the Committee, as do our other legislative representatives. I think Senator Lourie and I started on this Committee together a number of years ago. I will not tell you how many. But Senator Lourie when you have to leave, please excuse yourself and we will look forward to having you back. Yes sir, Senator McLeod.

McLeod - I was going to whisper in your ear but I'm going to have to step out around 11:30 but I shouldn't be gone long.

Harris - Both of these folks are lawyers.

Lourie - Just don't take advantage of the Senate while we aren't here.

Harris - We will try not to Senator. If any of the presentators have written statements, please give them to Sherri Craft and we will see that they get properly added in the records.

This will move us on into our formal agenda.

At this moment, the presentator is Helen Brawley, chairperson and Ollie Johnson, Executive Assistant to SC Commission on Aging.

Good Morning!

Helen D. Brawley
SC Commission on Aging
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REMARKS BY MRS HELEN D. BRAWLEY, CHAIRMAN
SOUTH CAROLINA COMMISSION ON AGING
to the
JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING, SEPTEMBER 20, 1989

Representative Harris and members of the Committee...

I am Helen Brawley, Chairman of the Commission on Aging. I am pleased to have the opportunity to speak with you this morning about how our agency is working to meet the needs and concerns of South Carolina's older citizens..

First, I would like to express my personal appreciation along with that of our agency to this Committee and to the General Assembly for the commitment and support that resulted in many pieces of legislation being passed during the first session.

For example:

Homestead Exemption Application
Long Term Care Insurance Regulations
Amendments to the Bingo Regulations
Continuing Care Retirement Communities Licensing and Regulations

We appreciate your efforts and support for an increase in the Homestead Exemption; and, ask your continued support for funding this increase.

I want to thank Keller Barron and her staff for their excellent cooperation and support on behalf of the elderly. Their assistance and guidance in legislative matters as well as many others has made it possible for the Commission on Aging to accomplish many more legislative goals that would ever have been possible.

The Commission has a mission statement that reflects our commitment to improve the quality of life for all older South Carolinians. Our vision is to have policies and programs that will support older persons in achieving maximum independence and self sufficiency. To strengthen older persons' capacities to remain at home intact in their families and in their communities, is our commitment.

According to our statistics our state's aging population is growing at a much faster rate than the national average. Since 1980 the number of senior citizens in South Carolina increased 46% - compared to only 24% nationally. We rank 3rd nationally in the number of retirees relocating to the state.

Our budget request reflects our commitment to expand services and enhance the capabilities of our Aging Network to serve this ever growing population.

We also agree with and support the legislative goals of the Council on Elder Affairs which address:

- Protection for Maintaining and Sustaining Independence of Older South Carolinians

- Strong Commitment and Support for the Commission's Budget Request

- Establishing State Policy that Assures Adequate Public Transportation

- and, Initiating Studies to Evaluate Current Programs and Services and Develop Appropriate Legislation to Address the Needs of Older South Carolinians

We as Commissioners, our staff, Area Agencies and Local Service Providers are diligently working together to create a better environment in which programs and services are planned, developed and delivered to older South Carolinians. Also, several issues such as configuration, quality assurance, and performance based contracting are being addressed through committees. These committees are comprised of representatives from all levels of our Aging Network to help us make decisions that are workable and will make a positive impact on the Senior Citizens whom we are here to serve.

We are pleased with the progress of these committees and will share results of our cooperative efforts with your committee.

Mr. Ollie Johnson, Executive Assistant to our Director, is going to provide further detail on our programs and budget priorities; and, at the completion of his presentation we will try to answer any questions that you may have.

I earnestly want you to give us any suggestions, advice or comments which we can take back to the Commission that will enhance our effects to provide services and solutions to the many problems facing our rapidly growing senior population.

Please feel free to call or write to me or any of our Commission regarding any matters that you feel needs our attention.

Again, I thank you for this opportunity to speak before you today.

Harris - Thank you, Helen! And I believe Ollie is next and I'm going to interrupt to make a little comment. You know there is one segment that the Homestead Tax Exemption has never addressed and that is those who are renters or tenants and coming down this morning I heard on the radio that the state of Minnesota allows a tax refund - a certain percentage on the amount of rent paid. This man had collected it for 2 years but they caught him the 3rd year. He was a resident of the state penitentiary in Minnesota. Still it gives us some idea of a course that we can pursue to give some relief to the renting public over 65. They said they caught him and he wasn't really a rent paying person but a resident of the state penitentiary of Minnesota. So I've asked Keller to see if she can get us some information on how this law works. Maybe your Commission will want to have a look at it also.

Brawley - I will follow that with great interest.

Harris - Ollie, come around.

(2)

PRESENTATION BY OLLIE L. JOHNSON, EXECUTIVE ASSISTANT
SOUTH CAROLINA COMMISSION ON AGING
to the
JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING
September 20, 1989

Ollie Johnson
SC Commission on Agi
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Chairman Harris, members of the Joint Legislative Committee on Aging, I am Ollie L. Johnson, Executive Assistant to the Director of our Commission. It is a pleasure to have the opportunity to present updates on several programs, issues and concerns being addressed by our Commission and our Aging Network. Also to present to you, and ask your support of our budget request.

May I express the regrets of our Executive Director, Mrs. Ruth Seigler, who could not be here today. Some time back our Commissioners selected Ruth to attend the National Leadership Institute on Aging at the University of Colorado. This Institute is sponsored by the Administration on Aging.

May I also recognize Representative Dill Blackwell who was selected by the S. C. Federation of Older Americans as their 1989 "Legislator of the Year" in recognition of his outstanding leadership and support on behalf of the elderly. Mr. Blackwell was recognized at the Federation's annual meeting last March.

As indicated by Mrs. Brawley, the Commission supports the goals and priorities developed by the Advisory Council on Elder Affairs. This group represents most organizations and advocacy groups with which we interact and most importantly has strong membership from older persons. Mrs. Miriam Patterson will present comments from that group.

As Mrs. Seigler noted in her presentation to this Committee last year, the Commission was facing many important decisions regarding configuration, quality assurance measures, and performance based contracting. In 1987 we were asked by the General Assembly to study the cost and benefits of establishing a statewide computer-based volunteer service credit program. We would like to update you on our progress:

1. The S. C. Commission on Aging's Committee to Study the Number and Placement of Area Agencies on Aging (SNAP) has completed its work. Its recommendation to have no more than 10 Multi-County Area Agencies on Aging was adopted by the Commission on June 7, 1989. We are working with local service providers in affected regions to designate AAA's and have them in place by July 1, 1990. I also take this opportunity to express our appreciation to Ms. Lillian McCreight, chairperson, and members of the SNAP Committee for their outstanding work in bringing a difficult task to a favorable conclusion. This report was previously shared with your Committee.

2. The Commission, in conjunction with the State Health and Human Services Finance Commission, Department of Health and Environmental Control, Department of Social Services,

Department of Mental Health, and the Department of Mental Retardation, is developing a Statewide Profile of Older Adults in South Carolina. This study will be a detailed survey of a randomly selected sample of older adults which will provide an accurate, reliable profile of the characteristics and needs of the older population in South Carolina. The data will be used by all state agencies supporting the survey and available to other agencies.

3. In September 1988, the Commission approved the formation of a Performance Based Contracting (PBC) Evaluation Committee. The Committee is chaired by Mrs. Erminie Nave, a member of our Commission. The Committee was comprised of representation from all levels of the Aging Network and included legislative staff. Performance Based Contracting is a contracting method by which providers are reimbursed at an established rate for the number of units of services provided. The Committee was charged with the responsibility for evaluating the impact of Performance Based Contracting on the delivery of aging services in South Carolina and for developing recommendations for improvements to the system. The report will be submitted to the Commission on October 11, as information, and distributed to the Aging Network for comment. The final report will be submitted to the Commission at its December meeting. A copy of this report and the Commission's decision will be shared with your Committee.

4. In 1988 the Commission received a two year grant from the Administration on Aging to design and implement a comprehensive quality assurance system for the Aging Network. The goals of this grant are to (1) assure that providers have the capability to provide acceptable levels of services, that are (2) consistent in quality; (3) that resources are commensurate with acceptable levels of service provisions; (4) that intended efforts of services achieved; and, (5) that the limited supply of services are provided to clients which are most in need.

   During the first year an Advisory Committee, its responsibilities and goals were established. Interviews were held with service providers, policy makers, and others concerning the quality of in-home services for the elderly. The interview explored current quality assurance activities, experiences and attitudes. Results of the interview were published in an "Assessment of Quality Assurance Activities in South Carolina's Service System for the Elderly." Service standards will be developed, field tested, and evaluated during the second year.

5. In 1987 the General Assembly mandated the Commission on Aging to study the cost and benefits of establishing a statewide computer-based volunteer service credit program (HR-233/S-252) to provide services to frail older persons. You have previously received the results of this study. The findings of this study indicated the cost effectiveness of such programs has not been demonstrated. As an alternative to the computerized credit program, the study recommends establishment of volunteer coordinators for each region to further the

recruitment and expansion of volunteers, and to better serve the elderly. The value of volunteer services is widely recognized. In addition to extending services that can be provided to the elderly, volunteerism provides older persons the opportunity to contribute to their communities and raise their self-esteem.

Now, I would like to direct your attention to some of the priorities of our 1990-91 budget request.

Our budget includes requests to strengthen the capacity of our agency, area agencies on aging and local aging service providers to meet the growing needs of Older South Carolinians. The report of the SNAP Committee recognized the need for additional funds and staff for enabling Area Agencies to fulfill their mission; this is reflected in our request. We are also asking for further incremental funding of Alternative Care for the Elderly (ACE) to provide community and in-home services for frail older persons who do not qualify for MEDICAID. We are requesting funds for a volunteer coordinator demonstration project as recommended in the study previously discussed and for a Regional Nursing Home Ombudsman program for the Appalachia region. We are also requesting funds to enhance and strengthen the capacity of the state agency to meet the many challenges and opportunities presented by the rapidly growing elderly population.

We are further requesting funds to annualize the 1989-90 cost of living benefit to area agencies and local providers and provide a 5% cost of living increase to these entities for the 1990-91 budget year.

In our non-recurring budget we ask your support for our request for funds to continue development and upgrading of the Management Information System for our Aging Network. We have also submitted a major request for funds to address the need to improve and strengthen the state's system of senior centers. In October 1988, your Committee asked that the Commission survey the need for improving and adding senior centers across South Carolina. This report will be submitted to our Commission on October 11 and shortly thereafter formally submitted to your Committee.

Our budget request contains needs identified in the survey.

- $562,900 to repair 39 existing multipurpose senior centers, satellite centers, and nutrition sites in 22 counties.

- $4,215,000 to construct 10 multipurpose senior centers in counties which currently have none.

- $566,125 to expand 12 facilities in 11 counties that need more space.

- $1,268,000 to establish 14 satellite centers in 8 counties to provide services to elders in areas which currently have no services.

Senior centers provide a focal point where older persons can come together for services and activities that enrich their lives and support their continued community involvement and independence.

My presentation reflects the Commission's commitment toward our vision that all older South Carolinians be able to achieve maximum independence and self-sufficiency and live meaningful and dignified lives within their community. We urgently ask your support for our budget requests which will help us accomplish these goals.

We sincerely thank the Joint Legislative Committee on Aging for your past guidance and support and look forward to your continued leadership on behalf of all older South Carolinians.

SOUTH CAROLINA COMMISSION ON AGING

BUDGET REQUESTS 1990-91

PRIORITY 1: BASIC OPERATING FUNDS **TOTAL STATE FUNDS**

This request reflects the cumulative impact of caps on federal administrative funds, across the board reduction of state funds, and ordinary cost increases due to inflation. Included are cost of living increments for federally funded positions, funds for mandated training, printing, and building rental increases.

$ 88,893

PRIORITY 2: EXPANSION OF AREA AND LOCAL AGING SERVICES

Funds are urgently needed to expand and enhance aging programs and services to help the rapidly growing numbers of older South Carolinians maintain their dignity and independence. This request includes funds to strengthen the capacity of Area Agencies on Aging meet their mandates in planning and coordinating aging services and in developing and allocating resources for local aging service programs. Funds are being requested to replace state funds for services lost in across the board reductions and to expand in-home services for frail elderly persons who do not quality for MEDICAID services.

Funds are also requested for development of volunteer services to expand the Aging Network's ability to serve older persons; and, a regional long-term care Ombudsman program is included for the Appalachian Region because of its high concentration of long term care beds.

$ 811,782

PRIORITY 3: PROGRAM IMPROVEMENTS

As the numbers and characteristics of the State's older population change, the Commission and its network of area and local agencies must be strengthened and developed to meet the demands and challenges created by this growth. Included in this request are funds to strengthen public information on aging issues, programs and services; education and training for professionals, paraprofessionals, and caregivers of older persons; quality assurance for aging services; technical assistance in management of aging services; and, planning to meet the needs of older South Carolinians.

$ 275,935

PRIORITY 4: COST OF LIVING INCREMENTS FOR CONTRACTORS

These funds are needed to annualize the 1989-90 cost of living increment for Commission grantees and contractors and to provide a 5% cost of living increase for 1990-91.

$ 395,510

TOTAL $1,575,119

SUMMARY OF NON-RECURRING BUDGET REQUEST

PRIORITY 1: MANAGEMENT INFORMATION SYSTEMS TOTAL STATE FUNDS

For several years the Commission has been developing and installing a Management Information System for the Commission, Area Agencies on Aging, and aging service providers. This includes a Client Information System for tracking services to older persons, a Service Provider Accounting System, and state-level program and fiscal data processing support. Due to limited resources, the various elements of the system are not integrated and are used on free-standing micro computer systems. This results in generation of paper copy data which must be manually re-entered for use by other agencies. This severely limits the efficiency of the system and increases costs for use of the system. Upgrading of the system is needed for management purposes and to meet the recent legislative mandate for information sharing among State human service agencies.

$ 163,540

PRIORITY 2: SENIOR CENTERS

Senior Centers provide a focal point where older persons can come together for services and activities that enrich their lives and support their continued community involvement and independence. In October of 1988, the General Assembly's Joint Legislative Committee on Aging asked that the Commission survey the need for improving and adding Senior Centers across South Carolina. Responses to the survey indicated that the majority of existing centers needed major repairs, that many centers need additional space, that ten counties have no centers, and that eleven satellite centers are needed. This request would fund the needs reported for improving and strengthening the state's system of Senior Centers.

$6,612,025

TOTAL $6,775,565

Harris - Do you want to take questions now before we hear from Mrs. Patterson? Helen indicated that after the presentation she would take questions.

Blackwell - Mr. Johnson, I appreciate all the nice things you said and I'm interested in Performance Based Contracting (PBC) but I'm also interested and disturbed that we are not tapping all of the federal sources of money that we might be using. I'm wondering if you would lead in an attempt to make sure that the delivery folks have some flexibility with their money and whether there's some federal monies that we are about to miss. I suspect that sometimes we don't move quick enough and because of that we miss some monies. I wish you folks would take that under advisement and see what we can do about that. I'll be interested in following up on that.

Johnson - We will follow up on that and see if there are sources. We certainly hope if any of the aging network folks find out about these sources they will let us know. We try to stay in touch with the staff people in Washington and that's what I have been doing.

Blackwell - I'm sorry Mr. Chairman but please indulge me just this much further. I think it's important that we keep records and we follow our rules but I also think it's important that there be enough flexibility so if we see needs they can be addressed. I want us to be able to tap those monies quickly rather than come down to end of year and find that we have missed out on them. I think you understand what I am saying.

Johnson - I understand what you are saying.

Harris - Mr. Johnson, I believe Senator McLeod has a question.

McLeod - Mr. Johnson, along the same lines about the PBC, the local providers had a real ruckus about it before and I don't want to mess up a good program by thinking we are going to save a dollar and it costs us two dollars.

Johnson - Most of the questions we had about PBC last year had to do with the competitive proposal issue and I think the Committee has pretty much addressed that in terms of providing funds to local Councils on Aging to ensure their continuity. Perhaps if new funds come down, they may be competitive but the Committee has not completed its work. I'm a little reluctant to say what's going to actually happen.

McLeod - I don't understand what you are saying about you are going to give each local council some core funds as to ensure that they can continue. It sounds like you are still going to put it on the competitive level.

Johnson - I don't know if all of it is going to be noncompetitive and I believe the Committee is still addressing that issue.

McLeod - On this Committee, I noticed you have some legislators' involvement but have you got some local people involved?

Johnson - Yes sir! These are representatives from the local Councils on Aging on that Committee. There was a concerted effort to get everyone involved.

Harris - Any further questions of Mr. Johnson?

Waldrop - As a follow-up on Senator McLeod's question will funds be distributed evenly throughout the counties in your needs request?

Johnson - Yes sir! We took a survey of the entire network and asked them to send to us what they felt they needed in terms of senior centers. Should they be repaired? Replaced? How much would it cost? There are some counties that don't have architectural drawings and they may have given us their best estimate but we surveyed the entire network.

Waldrop - One point blank question: Is there going to be anything for Williamsburg County? You can think about that and don't have to answer.

Johnson - I have a copy of our budget and I can tell you if we received something from Williamsburg County. I don't see anything in here from Williamsburg County indicating that they want any repairs and I'm looking at the portion that deals with existing multi-purpose centers that need to be repaired.

Waldrop - Well you know why I came up with that question.

Johnson - Yes sir. We are very sensitive to Williamsburg County. In my view we have been doing everything we can to continue services in Williamsburg County.

Waldrop - Let me make this statement and I'll quit. I'm going to tell you the reason I asked this. I'm a member of this Committee but I represent, I think everybody in this State. Though I think those folks were misled a little bit, anything possible to help them I would certainly appreciate and I'd like that for the record. I'd like to see Williamsburg County served and every county in this state as far as that goes to be served in its entirety. Nothing against your program, sir. I think ya'll do a fine program.

Johnson - Your point is well taken. We will be working to do everything we can for them.

Waldrop - Thank you.

Harris - Any further questions? Thank you, Ollie. Glad to have you with us. Now Miriam Patterson, Legislative Committee for Council on Elder Affairs.

Miriam Patterson
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1989-90

LEGISLATIVE PRIORITIES
ADVISORY COUNCIL ON ELDER AFFAIRS

Issues surrounding the ability of the elderly to maintain an independent and productive life on into their very eldest age, frame the legislative goals of the Council on Elder Affairs and the various constituent organizations in which the Council coordinates and collaborates.

We are very appreciative of the Joint Legislative Committee on Aging and the General Assembly in sponsoring and passing legislation which affects the well being of the elderly, such as LTC Insurance Regulations, Continuing Care Retirement Communities Licensing and Regulations, Homestead Exemption Applications, and raising the Homestead Exemption. We must keep the momentum moving forward in order to appropriately respond to the impact of rapidly changing demographics of the elderly population.

With this brief introduction, we have taken a number of legislative issues and organized them into several major goals. Our coalition efforts will provide testimony that centers around these goals:

GOAL I: Protection for Maintaining/Sustaining Independence of Older South Carolinians

GOAL II: Strong Commitment and Support for the Budget Request of the Commission on Aging

GOAL III: Establishing State Policy that Assures Adequate Public Transportation

GOAL IV: Continue to Initiate Studies to evaluate Current Programs and Services and Develop Appropriate Legislation to Address the Needs of Older South Carolinians

Goal I includes maintaining or sustaining independence for the elderly. This priority is so important to our state. By investing in legislation that promotes this concept, you allow older persons to maintain dignity and a high quality of life, while at the same time continue to pay their way for their needs:

Legislative areas that address this goal include:

1. Increase the Homestead Exemption (H-3043/S-12)

2. Increase the funding for the provision and expansion of community-based and in-home services. Of the Commission's original request for 2.5 million dollars, currently $250,000 is appropriated through the Commission's budget and $700,000 revenue is anticipated from bingo tax.

   We support the Commission's budget request for an incremental increase of $150,000 to provide additional community-based and in-home services for the frail older persons who do not qualify for Medicaid Community Long Term Care Services.

3. Encourage the State Housing Authority in coordination with the Commission on Aging to continue development of innovative housing options for low and middle income elderly such as shared, echo and subsidized housing.

4. Pass legislation to give a $300.00 tax credit for families who provide at least six months of continuing home/community based care for a frail elderly family member who has been certified by a physician as nursing home eligible. (H-3004/ S-13)

5. Increase monthly personal needs allowance for individuals in residential care facilities from $25.00 to $30.00.

6. Develop initiatives or pilot projects to test the establishment of Adult Day Care services for a frail elderly person as a fringe benefit for state employees.

7. Support for the continuation of the Dementia Registry.

8. Support for legislation that provides that batteries and cords for hearing aids be exempt from state sales tax (H-3368/S-296)

9. Support for Medical Durable Power of Attorney and Family Consent.

GOAL II: We would urge your careful review and support of the budget request of the Commission. The Commission is a small state agency with a total budget of $13,527,397, which includes $10,976,415 in federal funds. Approximately 90% of these total funds are distributed across the state to provide programs and services. In recognition of the growing elderly population and more importantly the frail elderly, the Commission is requesting 1.5 million in recurring funds to expand the Aging Network's capacity to plan and provide expanded in-home and community based services. The Commission's non-recurring budget requests 6.7 million to repair 39 senior centers, satellite centers and nutrition sites located in 22 counties; expand current facilities in 11 counties which are no longer suitable to meet the needs of the population served; and construct 10 multipurpose centers in 10 counties which currently have none. Senior centers are the focal point for provision of a variety of services, information and activities vital to seniors. The non-recurring budget also seeks funds to continue upgrading the network management information system.

GOAL III urges the strengthening of the state's commitment to allocating resources to assure adequate and appropriate public transportation. Adequate, accessible transportation continues to be a critical need for our elderly population all across South Carolina. We continue our support that 1/4 of one cent of the state gasoline tax be dedicated to public transportation and that this proviso be made permanent (Act No 197, 1987).

GOAL IV: There are several areas of aging programs and services that would benefit from studies initiated by the legislature, they include:

1. Initiate a study of Adult Foster Care services similar to program in other states.

2. We support the efforts of Senator Leatherman's committee to study health care costs.

Harris - Thank you very much, Ms. Patterson. Let me interrupt just one minute. I think if you will check your agendas. We want everybody to be fully heard. We don't want to miss anybody and for this reason we set out the time frames. Everytime you go over your time frame you infringe upon the presentators to come. We want everybody to be thoroughly heard but we have just gotten about 15 minutes off schedule. I hope that the rest of the presentators will try to keep it in the time frame. Next item on the agenda which is Ms. Connie Shade, President of SC Association of Area Agencies on Aging.

Connie Shade, President
SC Association of Area
Agencies on Aging
P.O. Box 850
Aiken, SC 29801

PUBLIC HEARING TESTIMONY

JOINT LEGISLATIVE COMMITTEE ON AGING

SEPTEMBER 20, 1989

S. C. ASSOCIATION OF AREA AGENCIES ON AGING

Rep. Harris, Members and staff of the Joint Legislative Committee on Aging, my name is Connie Shade. I am the Aging Unit Director of the Lower Savannah Council of Governments and am here today presenting testimony on behalf of the South Carolina Association of Area Agencies on Aging.

Today the South Carolina Association of Area Agencies on Aging wish to express our sincere gratitude to you for your continued support to study the needs and problems of the older citizens of South Carolina. Since the inception of the Joint Legislative Committee on Aging it has identified problems of our older citizens and sought solutions, and for this we are extremely grateful. We look forward to the upcoming session and the opportunity to work together to insure the highest quality of life for our older citizens.

The Older Americans Act intends that the area agency on aging shall be the leader relative to all aging issues on behalf of all older persons in the planning and service area. This means that the area agency shall proactively carry out, under the leadership and direction of the

State agency, a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community in the planning and service area. These systems shall be designed to assist older persons in leading independent, meaningful and dignified lives in their own homes and commmunities as long as possible.

In developing a comprehensive area-wide aging network system, the Area Agency undertakes annual planning activities to obtain updated information on the status and needs of the older citizens and prioritize those needs, inventory the resources and services available from public and private sources to meet the identified needs and evaluate their effectiveness; develop and administer a comprehensive area plan for their region; sub-contract program funds obtained by the Area Agency to local providers for the delivery of services; secure additional resources to asist local providers in developing new, innovative programs to benefit the older citizens of their region; provide technical assistance to local governmental jurisdictions and other human service provider agencies; and, serve as an advocate to enhance awareness by service provders, community leaders, civic groups, the corporate and voluntary sectors, and

elected officials regarding the identified needs and issues impacting the older citizens of the State.

The Area Agency is only one part of a total Aging Network which includes many diverse agencies including the Commission on Aging, county councils on aging and other local service providers, DSS, Health and Human Services Finance Commission, DHEC, mental health, social security, the private sector, etc. All of those agencies must work in concert to meet the ever increasing needs of the older citizens of our state. In meeting these needs, none of these agencies can stand alone. There must be inter and intra-agency coordination and memorandums of agreement that are implemented, not just signed, at all levels of the network. This necessitates planning, coordination and advocacy for the most effective continuum of care possible.

The responsibilities I just mentioned must be carried out in order to enhance the quality of life for our older citizens. A problem that all Area Agencies face is lack of funding for staff to carry out the functions of an Area Agency which are mandated by the Older Americans Act. We appear before you today requesting your support of the Commission on Aging's budget to fund an additional person at each Area Agency ($500,000). The addition of one (1) aging service coordinator in each area agency would greatly enhance the ability to

adequately and effectively meet the responsibilities as an area agency on aging. We request your support of the restoration of the previous cuts of State Grant Funds for Planning Districts. These funds are used by Area Agencies and county councils on aging primarily for matching funds for other Federal programs. Restoration of just the FY 87-88 reductions of $62,342 would allow the provision of an additional 2,300 hours of homemaker services; 7003 meals; and 79,690 units of transportation service to the elderly.

We support the Commission on Aging's budget request for training funds ($15,352). These funds will be used to maintain the Summer School of Gerontology; the Aging Network Training Conference; and the various other training programs at their present level. These programs are very educational and benefit the entire aging network, which consists of the numerous agencies I mentioned earlier in my presentation.

At the direction of the General Assembly, the South Carolina Commission on Aging conducted a survey to determine the need for improving or adding Senior Centers in South Carolina. The survey indicated an amount of $362,900 needed to repair 39 existing multipurpose centers, satellite centers, and nutrition sites. Ten counties, with a population of nearly sixty-thousand (60,000) older persons do not have a center. The cost for establishing 10

multipurpose senior centers in those 10 counties is $4,215,000. Eleven counties need additional space in order to serve more senior citizens. The estimated cost is $548,000. The additional space will enable the sites to serve an additional four-hundred and eight (408) older persons each day. The survey also indicated that ten (10) satellite centers in eight (8) counties were needed to reach those older persons who are not able to access the existing centers. The estimated amount is $1,148,000. We strongly urge state budget support for improving or adding Senior Centers in South Carolina. Senior Centers are the focal point for older persons to come together for services and activities to enrich their lives and support their continued community involvement and independence.

Three years ago the General Assembly increased the state gasoline tax and 1/4 of one cent was designated for public transportation activities. Many older South Carolinians can not access needed services due to the lack of transportation. We encourage your continued support of the 1/4 of one cent earmarking of the state gasoline tax for public transportation activities and ask that a portion of these funds be allocated to public transportation purposes for the elderly and handicapped persons.

The Area Agencies also support legislation to:

1) give a $300.00 tax credit for families who provide in-home care for a frail, elderly family member who has been certified by a physician as nursing home eligible;

2) exempt batteries and cords for hearing aids from sales tax;

3) allow dental hygienists to perform preventive services in nursing home settings, if the patients are "dentally indigent".

The Area Agencies support studies initiated by the legislature to:

1) study Adult Foster Care services similiar to programs in other states;

We appreciate the opportunity to come before you today and present our testimony on the issues affecting the elderly that are of concern to us and allow us to identify the areas in which we need your continued support in order to make a positive impact on the quality of life for the older citizens of South Carolina.

We applaud your efforts to date and look forward to working together in the upcoming session to insure the highest quality of life for our older citizens.

Thank you

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Joint Legislative Committee on Aging
September 20, 1989
Presented by Mildred McDuffie
Commission on Women, Commission on Aging Coordinating Council

Gentlemen and ladies: I first would like to thank you for the opportunity to appear before this able, esteemed committee. For many years you have struggled to address the needs of the elderly in South Carolina, and I appreciate your establishing this forum for public discussion. I congratulate you on your efforts.

This morning I come before you both as member of the South Carolina Commission on Women and current chair of the Commission on Aging Coordinating Council. The focus of the Council this year--and a concern of the Commission on Women for many years--has been caregivers for the frail elderly.

The statistics I am about to share with you will, I am sure, come as no surprise. In South Carolina over the next 12 years, the general population will increase 25 percent. The population age 65 and older will increase 75 percent, and the population age 85 and older will increase 246 percent.

Presently, the majority of those over age 65 are healthy, active and able to care for themselves. About 20 percent, however, have some functional limitation in feeding, ambulating, toileting or dressing. When someone reaches a level of frailty when three or more of these activities are limited, he or she is at greatest risk for institutionalization.

The present cost of nursing home care is $20,000 a year, and on any given day there are about 10,000 people residing in institutions. Because most do not have resources, the cost to the state is about $125 million dollars a year.

If we maintain the status quo, South Carolina will need 8,500 new nursing home beds by the year 2000. We know we can't build them all, and it's more expensive than we can afford. Besides, from talking with older people and their families, we know they would rather consider options other than institutionalization.

Because South Carolina has such strong family values, the family frequently would prefer to assume a major role in caring for the elderly. This caregiving role has traditionally been assigned to women in the family.

Nationally, in three-fourths of the cases, the caregiver is a woman--likely herself to be older and in poor health. A third are also poor. According the Older Women's League, in 1982, 72 percent of the providers of unpaid care to the frail elderly were women, and over half were age 45 and older.

To assume increased caregiving responsibilities, over eight percent quit work, and 20 percent worked fewer hours, took time off without pay or rearranged work schedules. In 30-40 percent of these households, providing unpaid care was the equivalent of a full-time job.

Nationally, in three-fourths of the cases, the caregiver is a woman--likely herself to be older and in poor health. A third are also poor.

We know that because of the declining birth rate and increasing longevity, women will now spend more years caring for aging parents than for minor children.

With increasing numbers of women in the workforce, employers are becoming aware of the difficult decisions women make in balancing needs of the family and requirements of the workplace. Many employers may be willing to assist in supporting caregivers.

We know that 50 percent of the nation's employers have established such policies as flex hours and leave policies, job sharing and voluntary part-time arrangements to help working parents care for their children. Perhaps they could examine the possibility of allowing such policies to be used for the care of frail elderly, as well.

Private sector and government involvement will be needed if we are to find creative solutions to the challenge of providing support for caregivers. One possibility for government involvement is providing respite services for caregivers.

Attached to this testimony is a model state bill, suggested by the Older Women's League. I encourage you to study the fact sheet and suggested legislation attached at your convenience. I would, however, ask you to consider:

1) Both humanitarian and financial considerations would lead us to believe that we should be exploring ways to avoid institutionalization. Essential to such a strategy is providing relief and support services to unpaid caregivers.

2) Already, family members--not government--provide most care for the elderly. The Department of Health and Human Services estimates that 60-80 percent of care received by impaired elders is provided by family and friends who are not compensated for their services.

3) Too often caregivers bear the total burden of providing care with little help from other family members of the community. This burden can result in physical, psychological and/or financial stress to the caregiver--and can lead to abuse or neglect by the caregiver.

4) Most unpaid caregivers are older women. Housebound, physically exhausted, often depressed, isolated and financially depleted, these women are likely themselves to suffer a breakdown. That could result in two dependent adults instead of one and a reluctant institutionalization-- with two persons eventually dependent on public assistance for their survival.

5) While primary focus may remain on the care needed by the frail elder, we cannot ignore the needs of the caregiver. Government services are needed to supplement, not supplant, spousal or family care. Respite care is one small step in relieving the burdens of full-time caregivers.

The model state bill attached to this written testimony addresses the need of caregivers for short-term or periodic relief. The bill does involve some cost to the state, and it may be that you will want to consider limiting the program at first to persons eligible for Medicaid.

Government, private sector and communities can come together to offer support for caregivers. We should begin to explore how much community support for caregivers might be created--or might already be available. Might churches offer adult day care as relief for caregivers--as churches have in the past offered child care as relief for mothers at home? Are there other community resources that may be able to provide respite care? Are employers able to offer support for caregiver/workers on a voluntary basis? What other governmental agencies/institutions might be committed to providing caregiver support?

These questions, we feel, should be addressed if we as a people are to meet the needs of our frail elderly--and those who care for them.

A wise woman once said: the debt passes forward. A much as we owe our elderly, we have a responsibility to our children to find cost-effective ways to meet these needs. In this case--a rare case indeed--the most cost efficient way is the way most elderly would prefer: care at home.

I pray we will be creative enough--and committed enough--to make that a possibility in South Carolina.

I thank you again for the good work you do and I appreciate your time this morning.

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RESPITE SERVICES FOR CAREGIVERS

Commentary on the Model State Bill

At both the state and Federal level, there is today growing attention to long term care alternatives to nursing homes for disabled adults. Both humanitarian and financial considerations are causing legislators to seek ways to enable persons who would otherwis be institutionalized, to remain at home. Essential to such a strate is the provision of respite care--relief and support services to unpaid caregivers.

It is family members, not government, who provide the most care for the elderly. The Health Care Financing Administration, of the Department of Health and Human Services, has estimated that 60-8 of the care received by impaired elders is provided by family member or friends who are not compensated for their services.

All too frequently these caregivers bear the total burden of providing care, with little help from other family members or from the community. This burden may be overwhelming, resulting in physical, psychological and/or financial stress to the caregiver. The consequence for the dependent adult may be neglect, or even physical or psychological abuse by the caregiver.

Most unpaid caregivers are older women. Because of the traditional role which society expects of women, and their greater life expectancy than men, the primary caregiver for a disabled elder is usually a wife or daughter. OWL's Gray Paper No. 7, "Till Death Do Us Part: Caregiving Wives of Severely Disabled Husbands," has documented the heavy burden laid on women who are caring for their disabled spouse or parent. Housebound, physically exhausted, often depressed, experiencing social, familial and personal isolation, as well as financial depletion, these women are likely themselves tc suffer a breakdown, or to abuse the person dependent on them for total care. Without community support for the caregiver, the result

may well be two dependent adults instead of one, and reluctant institutionalization, with both persons eventually dependent on public assistance for their survival.

Thus while the primary focus may remain on the care needed by the frail elder, we cannot ignore the needs of the caregiver. Government-supported services are needed to supplement, not supplant, spousal or family care. Respite care is one small step in relieving the burdens of fulltime caregivers. In today's budgetary climate, it is hopefully a small enough step to have a chance for enactment into law. Work on this legislative issue can help to focus public attention on the larger question of a long term care policy based upon the human needs of both frail elders and their caregivers.

In recent years legislation has been introduced in Congress, to extend benefits under Medicare and Medicaid so as to include respite care and other supportive services, and to provide financial incentives for families to care for disabled adults at home; however, such legislation has not yet been enacted into law. Action needs to be taken at the state level, as well as in Congress.

The model state bill attached is intended to address the need of the caregiver for short term or periodic relief, by establishi an administrative structure for the development and provision of respite services at the local level, and a financial structure which ensures that respite care services are available to all who need them, regardless of income. This bill could be attached to other long term care legislation, or approached separately. It should be noted that the bill does entail some cost to the state. Practical political realities in times of shrinking government budget may dictate that on the first round, the program be limited to persons eligible for Medicaid, but the ultimate objective is to ensure that no one needing the services is excluded.

An analysis of the separate sections of the bill is also attached

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RESPITE SERVICES FOR CAREGIVERS

A Model State Bill

SECTION 1. It has come to the attention of the Legislature that:
(a) 60-80% of the care provided for functionally disabled adults is delivered by family members or friends who are not compensated for their services. Family involvement is a crucial element for avoiding or postponing institutionalization of the disabled.
(b) Family or other caregivers who provide continuous care in the home are frequently under substantial stress, physical, psychological and financial. Such stress, if unrelieved by family or community support to the caregiver, may lead to abuse or neglect of the dependent adult.
(c) Because of their greater life expectancy and traditional role in the home, older women are, in most cases, the primary caregiver for disabled adults. The demands and responsibilities of the caretaking role impose special stresses on these women, who are coping with their own aging, often themselves in failing health, and suffering a depletion of their financial resources. The consequence may be two patients instead of only one, and institutionalization of the dependent adult, with an added burden on public funds.
(d) Respite care and other community-based supportive services for the caregiver and for the disabled adult could relieve some of these stresses, maintain and strengthen the family structure, and postpone or prevent institutionalization.
(e) With family and friends providing the primary care for the disabled adult, supplemented by community health and social services, long term care is likely to be less costly than if the individual were institutionalized.

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SECTION 2. Therefore it is the intent of the Legislature to provid a structure for the establishment of both in-home and out-of-home respite services which will provide relief and support to family or other unpaid caregivers of disabled adults:
(a) To encourage individuals to provide care for disabled dependents at home, and thus offer a viable alternative to institutionalization;
(b) To expand the coverage of services for the elderly and/or disabled under Medicaid, so as to include respite care services;
(c) To ensure that respite care and other supportive services are made generally available on a sliding fee basis to persons who are not covered under Medicaid;
(d) To assist families in securing the services, including respite care, counseling and information, which are necessary for their care of a disabled adult.

SECTION 3. Definitions
(a) Respite care services: Relief care for families or other caregivers of disabled adults. The services will provide temporary care or supervision of disabled adults in substitution for the caregiver.
(b) Eligible participant: An adult (1)who needs substantially continuous care and/or supervision by reason of his or her functional disability, and (2) who would require institutionalization in the absence of a caregiver assisted by home and community support services, including respite care. Income and assets are not criteria for eligibility.
(c) Caregiver: A spouse, relative or friend who has primary responsibility for assisting with the care of a functionally disabled adult, and who does not receive financial compensation for such care (or who receives compensation for such care under In-Home Supportive Services).
(d) Copayment: Financial participation in service costs by the participant being served, according to a sliding fee schedule based on the participant's income.
(e) Institutionalization: Confinement in a skilled nursing facility or an intermediate care facility.

SECTION 4. The Director of the State Department of Aging, herein referred to as director, shall administer this article, and establish such rules, regulations and standards as the director deems necessary in carrying out the provisions of this article.

SECTION 5. The director shall ensure that county-wide or regional agencies, either public or private non-profit, be designated or established, to provide or coordinate the following services:
(a) In-home respite care and other in-home supportive services, available to participants for a minimum of four (4) hours per week, including but not limited to the following:
(1) nursing services;
(2) home health services; and
(3) housekeeping, personal care, and chore services;
(b) Adult day care and adult day health care services;
(c) Short-term inpatient respite care (1) in an inpatient facility meeting such conditions as the State Department of Aging determines to be appropriate to provide such care, and (2) to be available to participants for a maximum of fourteen (14) days or 336 hours per ye
(d) Emergency respite care on a 24-hour basis for short periods, either in the home or out of home;
(e) Peer support groups for caregivers;
(f) Counseling services for caregivers and other family members;
(g) Educational programs for caregivers and for service providers; a
(h) Case management, coordinating the provision of the above services to participants.

SECTION 6. The director shall establish criteria for program eligibility, including financial liability, and shall assume coordination of existing funds and services.

SECTION 7. The State shall contract for those available services funded by this Act. Services which are not available shall be planned and developed.

SECTION 8. To ensure uniformity of services statewide, the State shall make grants and loans to entities to provide in-home or out-o home respite care programs in those areas which do not have adequat community-based long term care programs.

(a) In making grants and loans, the State shall give preference to areas in which a high percentage of the population is composed of individuals who are elderly, medically indigent, and/or disabled.
(b) In making grants and entering into contracts under this Act, preference shall be given to entities which establish programs to provide training for persons fifty (50) years of age and older who wish to become homemaker-home health aides or coordinators of caregiver support services.

SECTION 9. Data shall be collected to document the extent and nature of the need of unpaid caregivers, especially older women, for respite services.

SECTION 10. Any services provided for in this Act shall be in addition to any services already provided by Federal or state law, e.g., respite care under In-Home Supportive Services.

SECTION 11. Funding
(a) The State shall seek all necessary waivers from the U.S. Department of Health and Human Services in order to provide in-home and community-based services, including respite care, to persons who would otherwise face placement in a skilled nursing or intermediate care facility.
(b) Home and community-based services, including respite care, as set forth in 42 U.S.C. 1396n(c)(4)(B), shall be reimbursable as Medicaid benefits upon the approval of the Department of Health and Human Services. These home and community-based services, including respite care, shall be included in the Medicaid scope of benefits as covered and reimbursable services for the duration of the approved federal waiver and to the extent the State can claim, and be reimbursed by, federal financial participation funds for these services.
(c) Participants not eligible for Medicaid benefits shall, to the extent their income permits, contribute to the cost of services received The amount of copayment shall be determined by a single statewide sliding fee schedule, which shall be adjusted annually to reflect changes in cost-of-living. Copayment fees shall not exceed the actual cost of services provided to the participant.
(d) Medicare and other third-party payors shall be billed as appropriate These funds will be used to offset or supplement the capitation paid.

(e) Every insurer issuing an individual or group health insurance policy for delivery in this state which provides coverage for in-patient hospital care shall provide coverage for both in-home and out-of-home respite care services to residents in this state.

(1) Such respite care coverage shall be available to covered persons who are under the care of a physician, and for whom institutionalization would be required in the absence of a caregiver.

(2) Such respite care coverage shall be included at the inception of all new policies and added to all such policies already issued before the effective date of this Act, without evidence of insurability.

(3) Such coverage may be subject to an annual deductible of not more than $50 for each person covered under the policy and may be subject to the coinsurance provision which provides for coverage of not less than 75% of the reasonable charge for such services.

Sources

American Association of Retired Persons (AARP)
Older Women's League (OWL)
Department of Health and Human Services
Census Bureau
American Demographics
South Carolina Commission on Aging

Attachments

Public Policy Institute Fact Sheet: Long Term Care
Respite Services for Caregivers: A Model State Bill, Older Women's League
Respite Services for Caregivers: Analysis of the Provisions of the Model State Bill
Respite Services for Caregivers: Commentary on the Model State Bill

PUBLIC POLICY INSTITUTE

FACT SHEET

LONG-TERM CARE

Definition of long-term care

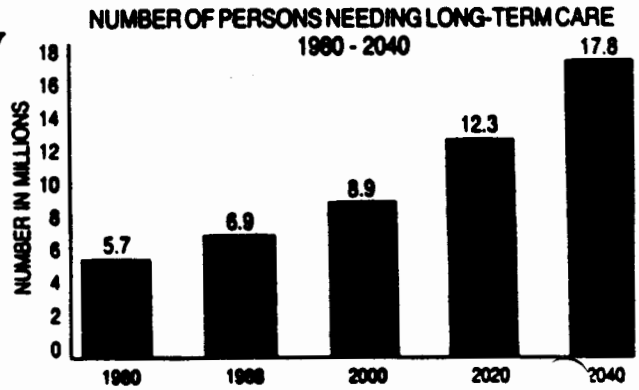
- Long-term care is a set of health care, personal care, and social services delivered over a sustained period of time to persons who have lost, or never acquired, some degree of functional capacity, as measured by an index of functional ability.

Long-term care as an important health policy issue

- The population over age 65 has grown by 56 percent in the last two decades. Increased longevity has added more years of life, but these are not always healthy years.
- The cost of long-term care is high and can lead to impoverishment. Most Americans have little protection against its high costs.
- Women provide most long-term care, both paid and unpaid, sometimes with considerable emotional or financial sacrifice.

The long-term care population

- Primary recipients are older people because of the higher prevalence of chronic illness. Other recipients include people who are developmentally disabled or mentally ill, and people with chronic infectious diseases like AIDS or tuberculosis. Chronic illness may lead to disability or functional impairment, increasing their risk of institutionalization.
- In 1985, there were 28.6 million people over age 65. Approximately 6.3 million of them had functional impairments, with 2.6 million of these being severe. About 21 percent of these individuals lived in nursing homes, with the remainder living in the community.
- People age 85 and older have the greatest need for long-term care services. Major reasons for institutionalization are disability and lack of family support.
- In 1988, about 6.9 million older people will need long-term care services. By the year 2000, the number of older Americans in need of long-term care will increase to almost nine million.



Source: Special Committee on Aging, U.S. Senate. *Developments in Aging*, February 1988.

AARP

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CC: Summer CN

Long-term care services

- Informal care includes unpaid help provided to someone who has some degree of physical or mental impairment. About 75 percent of disabled older persons living in the community rely exclusively on help from family and friends. About 72 percent of informal caregivers are women, either wives or adult daughters.

- Formal, paid care can be provided in the community or in an institution. There were 19,000 nursing homes in 1985, with 1.6 million beds. There were about 10,800 home health agencies in 1987, including 5,700 certified to participate in the Medicare program.

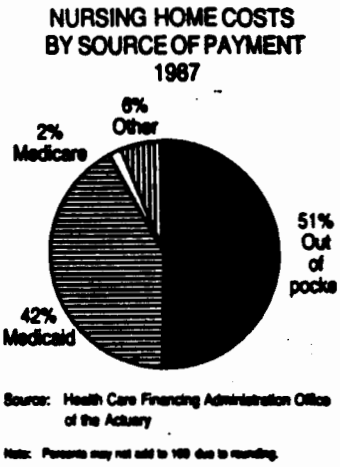
The cost of long-term care

- The average cost of a year in a nursing home in 1987 was $25,000.

- The cost of care at home ranges from $50 to $200 a day, depending on the needs of the individual.

- Indirect costs to family and friends include lost wages and benefits, reduced leisure time, and the added expense of paying someone to provide care.

Paying for long-term care



- In 1987, $41.6 billion was spent on nursing home care. Nursing home residents and their families paid about 51 percent of that amount.

- Medicare, Title XX, and other programs pay for some long-term care, but their contribution is not a major factor in financing these services. For example, Medicare spending amounted to less than two percent ($600 million) of total nursing home expenditures in 1987.

- Medicaid is the primary government program supporting long-term care services. It accounts for 87 percent of publicly funded nursing home care. In 1987, Medicaid's share of total nursing home expenditures was $17.3 billion (42 percent).

- Private health insurance paid less than one percent ($400 million) of total nursing home costs in 1987.

- About one-third of older people spending any time in a nursing home become poor. After only 13 weeks in a nursing home, 7 in 10 older Americans find their income reduced to the poverty level. Within a year, over 90 percent are impoverished.

8/88

For more information, write to Jane Tilly
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RESPITE SERVICES FOR CAREGIVERS

Analysis of the Provisions of the Model State Bill

SECTION 1 summarizes the background facts of which the Legislature takes notice and which provide the impetus for the legislation.

SECTION 2 states the intent of the bill: to ensure that respite services are made available to everyone who needs them.

SECTION 3 defines the key terms in the bill. (b) It should be noted that although it is the caregiver who will receive the respite, it is the disabled adult, not the caregiver, who is the "eligible participant", i.e., the person eligible for the services. This is to enable Medicaid and private health insurance coverage of such services.

(c) The "caregiver" who is addressed in this legislation is whoever has primary responsibility for the care of the disabled adult. It may be a spouse, relative or friend, as long as this person is not compensated for her or his services (other than limited compensation under In-Home Supportive Services, in states where such compensation is available to family members).

(d) "Copayment", the share of cost to be borne by the participant, is determined by the participant's income. The participant's assets are not included as a factor in determination of the copayment amount. This is an important but controversial principle, since this bill is not cost-free to the state. All too often the cost of long term care for a disabled adult results in the impoverishment of that person's spouse, as well, a situation which is not desirable. Therefore, in this bill it is only current, available income which determines the amount of the copayment.

SECTION 4 establishes which state agency shall be responsible for administering this law. The state agency which is most appropri- for this role will vary from state to state; e.g., in some states it may be the Department of Health (and Welfare), rather than the

Department of Aging.

SECTION 5 lists the services which should be made available, and which should be either provided or coordinated by county or regional agencies. Included are a wide range of respite and other supportive services, all of which are important elements of the respite care which is needed: in-home respite care, adult day care and adult day health care, short-term respite care in an inpatient facility, emergency respite care, peer support groups for the caregivers, counseling services, educational programs and case management.

In addition to periodic "time off" from the provision of care, many caregivers have stressed the vital importance of peer support groups, enabling them to express their feelings, and to help each other in practical ways. Professional assistance in the development of peer support groups increases the likelihood that they will be a key element of respite care.

SECTION 6 is intended to ensure the necessary coordination and oversight of the program at the state level.

SECTION 7: The State need not provide all the services itself, but may contract with local agencies in their provision. In areas where such services do not exist, the state has a responsibility to ensure their development. If politically feasible, you may choose to limit the provision of such services under this bill to non-profit agencies.

SECTION 8: In areas where there are not adequate respite services available, the state is encouraged to make grants and loans to aid in the development of such services. Special consideration should be given to organizations which will train older women, especially displaced homemakers, to assist in the provision and coordination of respite services.

SECTION 9: One function of this legislation should be to collect data on the existing need of caregivers, especially of older women, for respite services. Such data will be essential in laying the basis for further legislation in this area, or possibly for seeking to qualify a demonstration project for Medicare funds.

SECTION 10 stresses that the intent of the bill is to expand availability and scope of respite care, not simply to rearrange ting services. In some states, in-home respite care and adult health care services may already be available to Medicaid recipient.

SECTION 11 deals with the funding of the respite care to be ovided under this bill.

The Omnibus Reconciliation Act of 1981 (P.L. 97-35, Sec. 2176) permits the Secretary of Health and Human Services (HHS) to waive Federal requirements so that states can be reimbursed under Medicaid for home and community-based services, including respite care, which are provided to individuals who would otherwise have to be placed in a nursing facility. Paragraphs (a) and (b) deal with this waiver and the coverage of respite care under Medicaid.

(c) Persons not eligible for Medicaid shall be charged for the respite services on a sliding fee basis, based on the disabled adult's income. Since the amount charged cannot exceed the cost of the services provided, this means that the state will partially subsidize the cost of the services provided to persons at the lower end of the fee schedule. Since the alternative is likely to be institutionalization, with resultant financial impoverishment and eligibility for Medicaid, this cost of respite services borne by the state may well be less than the state's share in the costs of Medicaid would ultimately be.

(d) Where appropriate, Medicare and insurance carriers will be billed for respite services provided, thus diminishing the state's cost.

(e) This section is probably the most controversial provision of the bill, since it would require health insurance policies to cover respite services for persons who would have to be institutionalized in the absence of a caregiver. This provision could be omitted from the bill if political realities so dictated.

Finally, two elements considered but omitted from this bill: First, an alternative funding approach would call for the state to request that the Secretary of HHS waive Federal requirements so that Medicare coverage could be provided for a demonstration project offering respite services. Since this bill calls for the development and provision of respite care services throughout the state, the

"demonstration project" model seemed inappropriate here, but it might be considered as an additional strategy.

Secondly, the bill could include a provision for a state income tax credit to be made available to individuals who maintain in their home a person who would require institutionalization if not cared for in the home. The tax credit, related to actual care-related expenses, would offer a financial incentive to provide care at home. An example of such a bill, introduced in the California legislature in 1982, is reproduced here.

CALIFORNIA TAX CREDIT BILL

An act to add and repeal Section 17053.10 of the Revenue and Taxation Code, relating to taxation, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

The existing Personal Income Tax Law authorizes specified credits against the taxes imposed.

This bill would authorize until January 1, 1986, a credit of a specified amount to a taxpayer whose gross income does not exceed a specified amount and who resides in this state and provides care within his or her residence for an institution-bound frail elderly or disabled person, as defined.

The bill would take effect immediately as a tax levy.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and cited as "The Home Care Act."

SEC. 2. Section 17053.10 is added to the Revenue and Taxation Code, to read:

17053.10. (a) A taxpayer whose gross income for the calendar year in which the taxable year of the taxpayer begins is twenty thousand dollars ($20,000) or less for an individual, or forty thousand dollars ($40,000) or less for a joint return, and who resides in this state and provides care within his or her residence for an institution bound frail elderly or disabled person (hereafter referred to as "eligible person") shall be entitled to a tax credit against the amount of "net tax" (as defined by Section 17039). A taxpayer may claim that credit for up to three eligible persons for whom care is provided; however, the taxpayer may claim the credit for only one eligible person who is not related to the taxpayer. No more than one taxpayer may claim the credit for care of the same eligible person during any one year.

(b) The amount of the credit allowed by this section shall be two hundred fifty dollars ($250) for each eligible person residing in the taxpayer's home as a regular and consistent resident for at least six months during the taxable year.

(c) For purposes of this section, "institution-bound frail elderly or disabled person" means a person 65 years of age or older who would require institutionalization (as described in subdivision (d)) if adequate care at the home of the taxpayer was unavailable and having both of the following:

(1) Those chronic physical or mental limitations which restrict individual ability to carry out normal activities of daily living and which threaten an individual's capacity to live an independent life.

(2) Gross income for the calendar year in which the taxable year of the taxpayer begins of one thousand two hundred dollars ($1,200) or less and not more than fifteen thousand dollars ($15,000) in total resources. For purposes of this paragraph, "total resources" includes cash, securities, real property, the fair market value of interests in trusts, life estates or similar arrangements, and the fair market value of all other property and interests in property.

(d) The Franchise Tax Board, in determining the validity of any credit claimed pursuant to this section, may require the taxpayer to provide a written statement from an attending physician that the eligible person requires care similar to that offered at a skilled nursing facility or intermediate care facility.

(e) If the taxpayer elects to take the credit provided by this section, that credit shall be in lieu of any deduction under Section 17202 for providing home care subject to that credit to which the taxpayer otherwise may be entitled, if any.

~~(e)~~

(f) This section shall be in effect with respect to computation of taxes for taxable years ending before January 1, 1986, and as of that date is repealed, unless a later enacted statute, which is chaptered before January 1, 1986, deletes or extends that date.

SEC. 3. This act shall become operative only if the federal Community Home Health Services Act of 1981 (S. 234) is enacted.

~~SEC. 3.~~

SEC. 4. This act provides for a tax levy within the meaning of Article IV of the Constitution and shall go into immediate effect.

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Joint Legislative Study Committee on Aging
Public Hearing - September 20, 1989

Testimony Presented by Steven W. Hamm, Administrator
South Carolina Department of Consumer Affairs

Good Morning! I want to bring a couple of issues to you all in my role as both the Administrator of the Department of Consumer Affairs and in my role as Consumer Advocate. The General Assembly has designated the Department to be the regulatory attorney for the State representing the public in various regulatory activities for the Public Service Commission, Health Department, and in fact we have a number of cases that we are doing up in Washington involving telecommunication issues and others.

The first issue I want to address is Health Insurance. There has been a lot of comment and discussion about automobile insurance this past year. I have my fears that those comments and discussions are not over with yet. But auto insurance is not the significant insurance issue facing the citizens of South Carolina. Health insurance is. Indeed, my office has been involved in health insurance cases and I report that this Monday morning I argued a case in front of the S.C. Supreme Court in a matter involving the Insurance Department and a health insurance company. I had argued that the Chief Insurance Commissioner had granted to a health insurance company an increase greater than the evidence justified. I ultimately won that case in the Supreme Court and then unfortunately the Chief Insurance Commissioner asserted that he had no authority to direct the company to give back the money which they had unlawfully given them in the first place. I challenged that decision in the Circuit Court and I lost. Then this Monday morning I argued in the Supreme Court that it was not appropriate and that in this particular situation the health insurance company should be mandated to return those funds to their customers.

It is obvious that Health Insurance is an immediate interest to everyone and a special interest to the elderly and older citizens because health insurance is so very expensive. I will point out quite candidly in our advocacy program which was created in 1978 that we had the broadest responsibilities of any program of this type in the nation. We are the only one with health insurance, auto insurance, as well as utility matters. Unfortunately, although we have generated a legal record that is the best in the nation. We have been unable to get the kind of financial support in the General Assembly to allow us to hire the expert witnesses necessary to be involved in those kinds of cases. We have not had those funds adjusted above the inflationary amount in the last 10 years.

A couple of things I want to point out is the complaints. We are seeing a number of complaints that have particular impact on the elderly and I think there are those that are seeking out the elderly as victims and I want to remind you of what some of our complaint files are showing. We are seeing individuals and organizations selling burglar alarms and fire alarms that seem to be very much focused to the elderly with video presentations that are literally designed to scare people to death in an effort to sell vastly overpriced systems to people. I think are somewhat on the grey edge in terms of their ability to be oversold by various programs. I think we need to be aware of those kinds of things.

Another problem is in the area of pest control. We continue to have problems where pest organizations go into elderly people's homes and come out claiming that the home is infested with termites and pests. That is simply not the case or if indeed there is a problem, many times we find people being over charged which is a very difficult issue to deal with. We don't have a pricing statute in S.C. and I'm not going to suggest that we should, but I think this group, my agency, and all the other agencies need to be aware that there are those that are not at all hesitant to attempt to take advantage of the elderly.

Home repairs is another area where we see significant problems. We are looking at a complaint right now involving an elder S.C. citizen where my conservative guess is that they were charged three times what a local reputable organization would charge for home repairs. This has placed this individual in serious financial difficulty. It's affected their credit rating and indeed I think it was someone simply trying to take advantage of an elderly citizen. I would suggest that this group ought to be supporting legislation that monitors specialty contractors. In S.C. there are not any special requirements generally to hold yourself out as a plumber or certain other fields. I will remind you for example we are dealing with complaints in the Rock Hill area where a plumber routinely charges $217 just to get to the front door. The Attorney General and I are working on that problem and again it is a difficult issue. I think with some specialty contractors licensing or at least registering we would enable us to have a sense of who was out there and perhaps have an ability to deal with some of those kinds of problems.

Another problem is financial consultants. Anyone in this room can call himself/herself a financial consultant. Certainly in this era of inflation and rising costs some of our older citizens who have tried to save over the years and are trying to make good use of their financial resources might in fact turn to financial consultants and indeed lose a large part or all of their savings with these people. And again we have no regulations that deal with people that hold them out as financial consultants and again our older Americans are more likely to be impacted on this because some of themselves over the years have tried to demonstrate good citizenship and have tried to save for their later years and in fact they are being taken advantage of.

You might be interested to know the Department is now responsible for pawn shops. Pawn shop owners are telling me that they are seeing more and more older citizens using pawn shops to pawn various items to make ends meet. I just wanted to bring that to your attention. We are also seeing a growing number of check cashing organizations in this state. Elderly people are going to check cashing organizations but sometimes the amount to cash the check is 10% of the face amount of the check. Other states have had some serious problems with those kinds of organizations. Indeed, I'm in the process of drafting legislation for the General Assembly so we can at least monitor their activities and limit some of these charges and other problems.

The General Assembly this past year passed legislation dealing with Continuing Care Retirement Communities and made the Department of Consumer Affairs responsible for looking at those communities effective July 1, 1990. We have identified over 40 such institutions at this point. Very candidly given the budget situation, I'm not entirely persuaded that the General Assembly

while giving us that mandate is actually going to expect us to do it because I'm concerned about the level of funding necessary to deal with that statute. This is a very significant piece of legislation simply because we are expected to look at the financial stability of that organization to ensure when citizens go in there and spend large sums of fees, the organization has a reasonable expectation of continuing over time. It is a tremendous liability on the Department of Consumer Affairs to reassure citizens that in fact that particular institution is capable of meeting that obligation under the terms of the contract which involves a detailed financial accounting and review. And I'm extremely concerned that the General Assembly is not going to fund that program in such a way that I can adquately assure citizens a particular facility licensed by the Department in fact meets those very specific financial requirements.

I'll finish with one final issue that I think you ought to be aware of and it's an issue broader than just the state of S.C. It involves a lot of money. There is legislation in Congress right now dealing with utilities and regulated utilities in all the states. Utilities in S.C. collectively presently hold over $300 million that they collected for federal income tax purposes that under the terms of the 1986 Tax Reform Act are never going to be sent to the federal government. The utility industry wisely included in that legislation that the states could not look at that over collection and the states could not mandate that those refunds be made in a timely fashion. Indeed the refunds might be made as many as 20 or 30 years from now. I would suggest that in terms of the impact on the elderly who has high rates of federal income taxes that will never be paid to the federal government, it is going to be a small consolation to find out the refund is going to flow back to them over the next 30 years when in fact they might not be here for that period of time. I have urged all members of our congressional delegation to support that legislation. All members of our congressional delegation are not supporting that legislation and I would hope that this group would suggest that we allow each state to determine the appropriated handling of these large sums of money. Thank you!

Harris - **Thank you very much! And I know there are going to be some questions.**

Blackwell - **Mr. Chairman, I detect from this last report to us that this is something that we as a Committee probably ought to go on record with our Congressional delegation. I would ask you as Chairman to instruct staff that they get with Mr. Hamm and get an appropriately worded resolution for us to forward to them. Mr. Hamm, back to your health insurance, do you detect a need for legislation in the state in connection with the problems with the health insurance?**

Hamm - **Well, I believe everytime I go to court that I'm right even if I don't win. But I have hopes obviously that the Supreme Court will agree with my position and assert as I did that the Chief Commissioner had the authority to direct those refunds to take place. I will tell you that if the Supreme Court issues a ruling stating that he doesn't have the authority and the company gets to keep the money, I will draft legislation.**

Blackwell - This Committee at least speaking as one member would be glad to do all that we can to get that legislation passed.

Hamm - I have great hopes that I was persuasive enough. So the Supreme Court will reverse that decision but we will simply have to wait. But I thought it was the kind of thing I thought you needed to be aware of.

Harris - We will certainly take that under consideration at the Committee level. Are there any other questions of Mr. Hamm? Steve, I want to thank you for the job you are doing and thank you for coming over today. One question on these specialty contracts? Should that be handled at the state level?

Hamm - Yes sir! There is legislation floating around and I know there are members of the General Assembly concerned about it and feel like it is burdensome on the local people. I can appreciate that. Ya'll are going to have to make some fundamental decisions. If you have a larger vision, that larger vision should include our older community as well as citizens in general. There ought to be some standard if someone wants to say they are a plumber or some sort of repair person. We have complaints now where people went in to do one repair and they did basic structural damage to a consumer's home because they didn't know what they were doing and I would hate for that to continue.

Harris - Thank you very much! We have an important message for Mr. Jim Califf. Moving on to the next presentator one well-known to the Committee, Fletcher Spigner, Executive Director of Council on Aging of the Midlands.

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COUNCIL ON AGING OF THE MIDLANDS

PRESENTATION BY FLETCHER SPIGNER, EXECUTIVE DIRECTOR

TO THE JOINT LEGISLATIVE COMMITTEE ON AGING

PUBLIC HEARING

SEPTEMBER 20, 1989

Good morning. My name is Fletcher Spigner, and it has been my pleasure and priviledge to serve as Executive Director of the Council on Aging of the Midlands for over the past fifteen years. I have watched our aging network change in so many positive ways, and some of those changes have come in some pretty turbulent times. But we have survived, and I can tell you that Councils on Aging throughout the state of South Carolina are alive and full of energy to take on the challenges that face us in the 1990's and beyond. The South Carolina Association of Council on Aging Directors has become a real driving force in aging network politics and policy making, and I believe that what we, who have the priviledge and experience the pleasure and pain of working with our older citizens every day, have to say and contribute is of the highest importance to the future of our state.

I am not here today to advocate anything that is unique or innovative, and I am not here to stir up controversy. There are others who are better able to do both of these than I am. I am here solely for the purpose of advocating for those older people who are at home and at risk - those people for whom we simply do not have sufficient resources to allow them the dignity of living a quality and decent life.

Almost 35,000 people in our country are 100 years of age or older. There are 500 South Carolinians 100+, and the Council on Aging of the Midlands serves 60 centenarians among its 9,500 clients. South Carolina's illiteracy rate of 25%, some say 35%, is double or triple the national rate. 25% of our older population live in poverty, and this is almost twice the national rate. By the year 2000, one in eight of us will be 65+. By the year 2030, one in five of us will be 65+.

The Council on Aging of the Midlands is a private, non-profit organization serving older people primarily here in Richland County. While we are the largest organization in South Carolina exclusively serving the needs and interests of older people, we are typical among Councils on Aging in our dedication and desire to meet the day to day needs of our state's older people. Our Council has a 2.5 million dollar budget, derived from over 45 different funding sources, and a growth rate of at least 15 to 25% every year.

In one capacity or another, we serve between 7,500 and 9,500 clients. Our organization receives 87,000 incoming telephone calls a year, and our programs and services, especially those for homebound older people, have waiting lists.

The Council on Aging has assessed 11,000 clients in their own homes since 1981, and today 4,000 of these assessed clients are active clients on our rolls. 2,000 of these clients have three or more impairments each. Many live alone in poverty; go without hot baths or showers; don't get to the doctor when they need to; don't vote because they can't get to the polls; seldom, if ever, eat hot meals; lie around in the same night clothes day after day; and generally live in clutter and dust. This state must focus on these essentially disenfranchised and forgotten older people. They are alive and not well, living in their homes, frequently by themselves, very frequently in poverty, illiterate and unable to help themselves, unless we come forth to do so in the name of God and human dignity.

The greatest need among older people is the need for food preparation assistance, with transportation, housecleaning, the ability to leave home and just walking around rounding out the top five.

The picture becomes even clearer as the focus becomes more narrow. In Richland County, for example, 400 of our clients are severely isolated, depressed and/or chemically addicted. 560 are severely disoriented and confused, and 400 others have been hospitalized in the last two years. These are people who live in their own homes, most likely by themselves, not in institutions.

I wish I could bring these clients to you so that you could see and feel their needs.

Consider this profile of real people served last year in a special agency effort supported by one of Columbia's finest corporate citizens, the South Carolina Electric and Gas Company: the average age, 78 years. 47% lived alone. 53% had at least one psycho-social problem. Over half had four or more health problems. Almost half had five or more health problems. Nearly all had impaired vision and almost half impaired hearing. Four out of five could not walk without assistance. Over half could not bathe without assistance. Half could not dress without assistance. Almost half could not use the bathroom without assistance. And almost half experienced bowel or bladder incontinence. Two-thirds had high blood pressure. Almost two-thirds had heart problems. One in four had diabetes. Three out of four had arthritis. And one out of four had kidney problems. One in five had a history of psychiatric problems. One in five had serious neurological problems. And one-third had serious respiratory problems. 98% of these clients needed assistance with house cleaning, food preparation or transportation. The average number of medications per person was five. It is no wonder that 40%, almost half, experienced confusion, and almost half, one in two, were hospitalized at least twice during 1988.

These are real people, in their homes, many living alone, many in poverty, and they are disenfranchised because they are not visible to you and me and they can't even get to the poles to exercise their right and responsibility to tell us how they feel and what they want.

The Council on Aging provides over 20 programs and services to older people in our community. The Retired Senior Volunteer Program, for example, recruited almost 900 volunteers who worked in over 85 different organizations last year. They gave 120,000 hours of service, or $400,000 worth of donated time. Over 500 Meals-on-Wheels volunteers donated 17,000 hours of service delivering meals to over 400 homebound people every day last year. And the Agency provides Homemaker Services, Respite Care Services, Sitter Services and many, many others.

But when you look at all of our services, and all of the other services being provided by many other fine organizations, they pale by comparison to the documented needs faced by an essentially disenfranchised people.

Councils on Aging throughout the state are in a wonderfully-unique position to be of great service to older people. Through our programs, we serve older people and make it possible for older people to serve themselves and others, young and old alike. Aging is what really binds all of us together, because it is the one thing we do together.

Our state must rally in support of our parents and grandparents, in support of our friends and relatives, and in support of those who are strangers to us.

Most all of the money we receive is earmarked, and it is not nearly enough to meet the current documented needs. Only 7% of our budget comes from the United Way, a great community organization, and another 12% from the local County Council. These dollars are flexible but make up not quite 20% of our total budget.

In Richland County there are 175 people waiting for home visits, some of them for as long as nine months. A home visit is a prerequisite to receiving needed services. In July alone the Council on Aging received 258 referrals for service, for programs that have waiting lists.

Historically, and unfortunately still the case, social service dollars in our community are channeled to agencies and programs serving children at a rate of seven to ten times that which is channeled to services for older people, despite the decreasing numbers of 5 to 17 year olds and the fact that the 85+ population will double from 1980 to the year 2000.

The future of the aging program lies squarely in the hands of people like you and me. The aging program needs financial resources which are flexible, enabling us to serve people on waiting lists and those who fall between the cracks. Flexible resources like United Way and local government funds, and there are over 400,000 different reasons, good reasons, why the state of South Carolina should place a higher priority on providing flexible state dollars to serve those people who could not be here today even if they wanted to.

We must care about our state so much that we are no longer willing to allow any older person to live out his last years without a hot bath, without a hot meal, without a daily change of clothes, or without a warm and caring contact with the outside world.

Thank you.

Harris - Thank you very much! Any questions of Mr. Spigner? The Midlands area is indeed fortunate to have you. You have given us a challenge. Representative Blackwell has just commented that these are some of the questions that he wanted some answers to and you have given us a challenge. We will try to respond. Thank you so much for being with us. Next presentator is chairperson, Dr. Richard Cowling, of SC Nurses' Association.

Dr. Richard Cowling
SC Nurses' Association
College of Nursing
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W. Richard Cowling, III, Ph.D., R.N.
Associate Professor and Chair
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Member, Council on Gerontological Nursing
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The interest of the South Carolina Nurses' Association Council on Gerontological Nursing is the health and well-being of the elderly citizenry of South Carolina. Our goal in providing testimony this year is not to promote a particular legislative agenda, but rather to advocate a "legislative consciousness" that will guide the development of new legislation. This is critical because I fear that our approach to the needs of the elderly has often been guided by misconceptions and outdated knowledge about the elderly. In the past the focus on legislative initiatives has been oriented to the plight of the elderly which is well-documented and rehearsed in front of legislators every year. While a legislative agenda oriented to the needs and problems of the elderly is a commendable societal endeavor, a legisative agenda that is not guided by an enlightened and newly informed consciousness of the elderly and aging circumvents the range of legislative possibilities. This new consciousness of aging and the elderly is based on more than what is possible; it is based on what is known and what is already happening today; it is based on research and scientific findings; and it is based on stories the elderly are telling society about themselves.

The facts are clear and their impact is gaining

momentum. Contrary to popular beliefs, the following is becoming more and more evident:

1. People over 65 are not old. "There are neither biological nor psychological reasons to connect the number 65 to the onset of old age" (Dychtwald, 1989, p. 32). Chronological age is not a clear marker of the abilities and capacities of the elderly.
2. Most older people are relatively healthy. Old age and disease are not the same. "While older people may have chronic, controlled health problems as they age, they are not necessarily bothered or limited by them" (Dychtwald, 1989, p. 34).
3. Older people are not rapidly deteriorating in mental capacities. "Of the 30 million Americans over the age of 65, only 10 percent show any significant loss of memory, and fewer than half of those show any serious impairment" (Dychtwald, 1989, p. 38). Sharpness and understanding are likely to increase with age if one continues to challenge himself or herself.
4. Older people are productive. "No consistent pattern exists to show the superior productivity of any age group" (Dychtwald, 1989, p. 41). In fact research shows that older people are likely to stay with a company longer, have fewer on the job accidents, experience less job stress, make fewer errors, and make wiser decisions than younger workers.
5. Old people are not the same. "People in their later

years become more, not less, diverse. And tomorrow's elders will be different not only from one another, but from today's elders as well" (Dychtwald, 1989, p. 48).

Taking these facts into consideration, a new "legislative consciousness" can be created from which to formulate legislative initiatives. Guided by this consciousness, legislation serves as a foundation for creating the conditions for elder empowerment rather than as a mechanism for promoting elder dependency. This is not meant to convey that legislation should not be responsive to the needs of the elderly. Rather it implies that responsive legislation be structured to capitilize on the elderly as their own best resource and to extend the possibilities of health and growth in old age. Attention should be given to legislation which would provide the legal and financial foundation for innovative programs to support elderly self-care and self-management.

It is time to have the state of South Carolina show innovation in its own state employment system as a model for the private sector. Acknowledging that chronological age is an unfair marker of the abilities and potentia_ of older people, a close look at how people are retired is a necessity. Some programs in corporations in other states have used concepts such as phased retirement and retirement rehearsal. These allow the older person a chance to sample retired life in preparation for retirement or assure the older worker a return to a job if retirement does not fit for

him or her. Additionally, some companies foster part-time work in preparation for retirement by having prorated benefits packages which are essential to the quality of life of the older person. Some corporations even bring back retired employees for "casual employment" allowing them to work a certain number of hours without losing retirement benefits. This allows the company to gain from the expertise and wisdom of the older person.

State support for programs that utilize the elderly to attend to elderly problems and needs would be one way to actualize a new "legislative consciousness" in relation to aging. It is well-documented that the elderly are a rich resource of energy, knowledge, and skills. Perhaps it is time to ask the question, to what extent could state funds be used to support the development of programs that are elderly-centered and would result in financial savings for the state? For instance, Blue Cross/Blue Shield has an Ambassador Corps of elderly volunteers with backgrounds in insurance, accounting, or teaching. These ambassadors explain the confusing interaction between Medicare and their private insurance policies to older subscribers, some who are bedridden. Ambassadors experience the respect, appreciation, and satisfaction of helping others while the consumers get helpful personal attention and financial savings. Likewise, retired nurses, physicians, and allied health care workers could be utilized as health care advocates for health education and outreach services.

A third area of legislative initiative could be focused on tooling the state system of higher education for a learning lifestyle congruent with older person's needs. As fewer number of college-age individuals arrive at the doors of our universities, there is a strong indication that the elderly are an untapped market for educational programs. College towns are becoming choice retirement locations for the education-minded elderly. Some colleges and universities around the country are responding by building their own specialized adult communities with a focus on lifelong learning. Complete self-study programs have been developed for older learners who are unable to attend formal classes. The University of North Carolina is in the process of opening what is considered to be the most comprehensive higher education program aimed at older Americans.

Finally, recent state monies allocated for research show promise. Seed funding and shared funding for advances in knowledge about health promotion interventions and program development aimed at health enhancement outcomes for the elderly would be a valuable investment. The potential for maintaining and extending the health of older people through fitness and active lifestyles is evident. In 1987, more than 50,000 elderly participated in regional "Senior Olympics" across the country. Support of health promotion research could lead to future cost savings for all concerned.

I have appreciated the opportunity to share a perspective on aging to guide legislative possibilities. I

would also like to offer the support of the Council on Gerontological Nursing in legislative development.

Reference

Dychtwald, K. (1989). Age wave: The challenges and opportunities of an aging America. Los Angeles: Jeremy P. Tarcher.

Harris - **Thank you very much, Dr. Cowling. Are there any questions of Dr. Cowling? I have a little side comment. I met Monday with Dr. Pitts, Dean at the School of Nursing at Clemson University. She indicated that strong emphasis should be placed on gerontological nursing. So we are happy to see this happening in our state universities. We appreciate your remarks and look forward to working with you.**

Cowling - **We thank you for your support.**

Harris - **Miss Denise Wiles, Program Director for the Elderly Assistance Line.**

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WRITTEN TESTIMONY PROVIDED TO THE JOINT LEGISLATIVE COMMITTEE ON AGING BY THE ELDERLY ASSISTANCE LINE

Public Hearing - September 20, 1989

For over seven years, the **South Carolina Handicapped Services Information System (SCHSIS)** has actively and effectively served the citizens of South Carolina as a statewide system providing information on services available to persons with disabilities of all ages. In 1987, Mr. John Winthrop, a philanthropist from Charleston, was interested in seeing a statewide system similar to **SCHSIS** developed for senior citizens. He saw a tremendous need to provide all senior South Carolinians, both disabled and non-disabled, with a central source of information about exactly what services are available to them. Mr. Winthrop was also a member of the Brookdale Foundation out of New York and was instrumental in convincing the Brookdale Foundation to fund the Elderly Assistance Line in South Carolina. The need for such a system becomes more critical considering the projected rate of growth in South Carolina's elderly population during the coming years. As we approach the end of our two-year funding period, I am happy to have this opportunity to share with you information about the growth and expansion of the **Elderly Assistance Line** as well as a few of its many accomplishments.

The **Elderly Assistance Line**, as a component of the **SCHSIS**, is a statewide, computerized information and referral system providing easy access to needed information through the use of a toll-free telephone number. This approach maximizes the economy of scale and provides a comprehensive I & R system at a fraction of the total cost. Since November 1987 our staff has been actively involved in collecting data on agencies all over the state that provide services to persons who are over the age of fifty-five. This information on available services supplements the **SCHSIS** database.

The information in the database includes service listings from a wide variety of organizations such as state agencies, hospitals, private associations, voluntary organizations, support groups and much more. A wide variety of services including, but not limited to, retirement and adapted housing, meals, homemaker services, transportation, recreation, peer and family

support, medical services, and special equipment are also contained in the computer database of the **Elderly Assistance Line.**

The goal of this computerized information and referral system is to provide callers with the most current, complete and pertinent information to access needed services. Therefore, updating present information on providers and adding new providers as they are identified is a tedious, yet an on-going process.

When a call is received, a trained counselor assists the caller to determine the service(s) needed. Based on the service needed and the county in which the caller resides, the counselor uses the computer to search files to obtain information on providers offering that service. The counselor is then able to provide the caller with a detailed description of the service(s), the name, address and phone number of the provider offering the service, and the name of a contact person with whom to speak. Additionally, information on hours of operation, accessibility, transportation, eligibility, etc. is also available. The following are just two examples of calls received by our counselors on a typical day:

Rachel is a 74-year-old woman living in Greenville County. She suffers from a heart condition which requires her to take several different types of medication, all of which are quite expensive. The only income she has comes from *Social Security*, and her only insurance is *Medicare*. With such a limited income and no insurance to cover prescription medications, Rachel is concerned that she may have to choose between paying her utility bills and buying the medications she so desperately needs. Fortunately, our **Elderly Assistance Line** counselor is able to offer Rachel an alternative. The counselor explains that there is a program called the "Searle Program for Patients in Need," in which her personal physician may enroll. Once enrolled her doctor can provide Rachel with free medicine if she is able to take medications which have been manufactured by the Searle Company.

In talking with Rachel, the Elderly Assistance Line counselor learns that Rachel is also experiencing difficulty meeting her other living expenses such as food, heating and telephone. For assistance with her food bills, the counselor suggests Rachel apply at her local *Department of Social Services* for Food Stamps. To assist with her heating bills, she explains that the Energy Assistance Program with *Sunbelt Human Advancement Resources, Inc.* may be able to help her. She also suggests several charitable organizations, such as *Baptist Network for the Blind*, *Crisis Ministries* and *Good Samaritan Mission*, which may might be able to help on a one-time financial basis.

With this information, Rachel is encouraged that she will be able to meet her financial obligations while her health needs are met at the same time.

Steven is an 89-year-old man living alone in Aiken County. His wife died several years ago; and, he has no children. His closest relative, a niece from Athens, Georgia, has come to visit and is concerned about the condition in which she has found her uncle. She looks in the phone book and calls the **Elderly Assistance Line** seeking information and direction as to what she should do. She states that her uncle absolutely refuses to leave his home to live with her; yet, he lacks the necessary resources to properly care for himself without some assistance. He is still quite alert mentally and

fairly active physically, yet living alone with little or no stimulation, he sometimes becomes disoriented. Because he can no longer drive, performing simple daily tasks, such as shopping for groceries or getting to his doctor's office, is almost impossible.

After carefully listening the **Elderly Assistance Line** counselor suggests that the niece call the local *Council on Aging* in her area and ask that an outreach worker/case manager come visit her uncle. The counselor explains that, during the visit, the outreach worker will be able to access all of her uncle's needs and determine how the *Council On Aging* would be able to serve him. The **Elderly Assistance Line** counselor further explains some of the services provided by the *Council On Aging* that might benefit her uncle: local transportation for shopping and doctors' appointments; homemaker services which could assist him in his household chores; Meals-on-Wheels which provides a hot noon day meal; or congregate meals at a senior center where he might spend time with other people his age as well as participate in various recreational activities.

The **Elderly Assistance Line** counselor also informs her about "*Aging Network Services*", a private case management system which would assign a case worker to her uncle. The case worker would be responsible for visiting her uncle on a regular basis and for ensuring that Steven's needs are met. The case worker would report any changes in Steven's condition to the niece.

As a final suggestion, the **Elderly Assistance Line** counselor tells Steven's niece about the *Lifeline System* which is available through the *Aiken Community Hospital.* Once the *Lifeline* unit is installed in Steven's home, Steven would have direct access to the hospital, police department or a designated individual at a touch of a button in the case of of an emergency. Such a system would provide both Steven and his niece with the peace of mind they need.

Another important benefit of the **Elderly Assistance Line** is its ability to identify gaps in services available in the local community as well as on the county and state level. Identifying what services are not available is, often, as important and useful as identifying what is available. Such information can be especially useful to those who are responsible for providing and planning services to the elderly population of South Carolina.

Enclosed you will find a compilation of statistics reflecting the growth of the **Elderly Assistance Line** and the activities of its staff. As you examine these statistics, you will certainly notice the steady increase in calls received by our counselors. This, we feel, is due to an ever-growing awareness of the **Elderly Assistance Line** by consumers and agency representatives alike, and is a reflection of the great need for such a system in South Carolina.

The **Elderly Assistance Line** is a valuable resource to South Carolina's senior citizens, their family members, and agency representatives interested in their well-being. Needing services and not knowing where or how to find them is a most frustrating and confusing experience. The **Elderly Assistance Line** exists to make the experience of locating services for senior citizens an easier task.

ELDERLY ASSISTANCE LINE
Update of Activities
January 1989 - August 1989

Number of Brochures Distributed:	20,782
Number of Presentations/Displays/Meetings:	59
Number of Publications in which the **Elderly Assistance Line** was mentioned:	35

Major Public Awareness Activities

A description of and brochure for the **Elderly Assistance Line** was provided to each of the following:

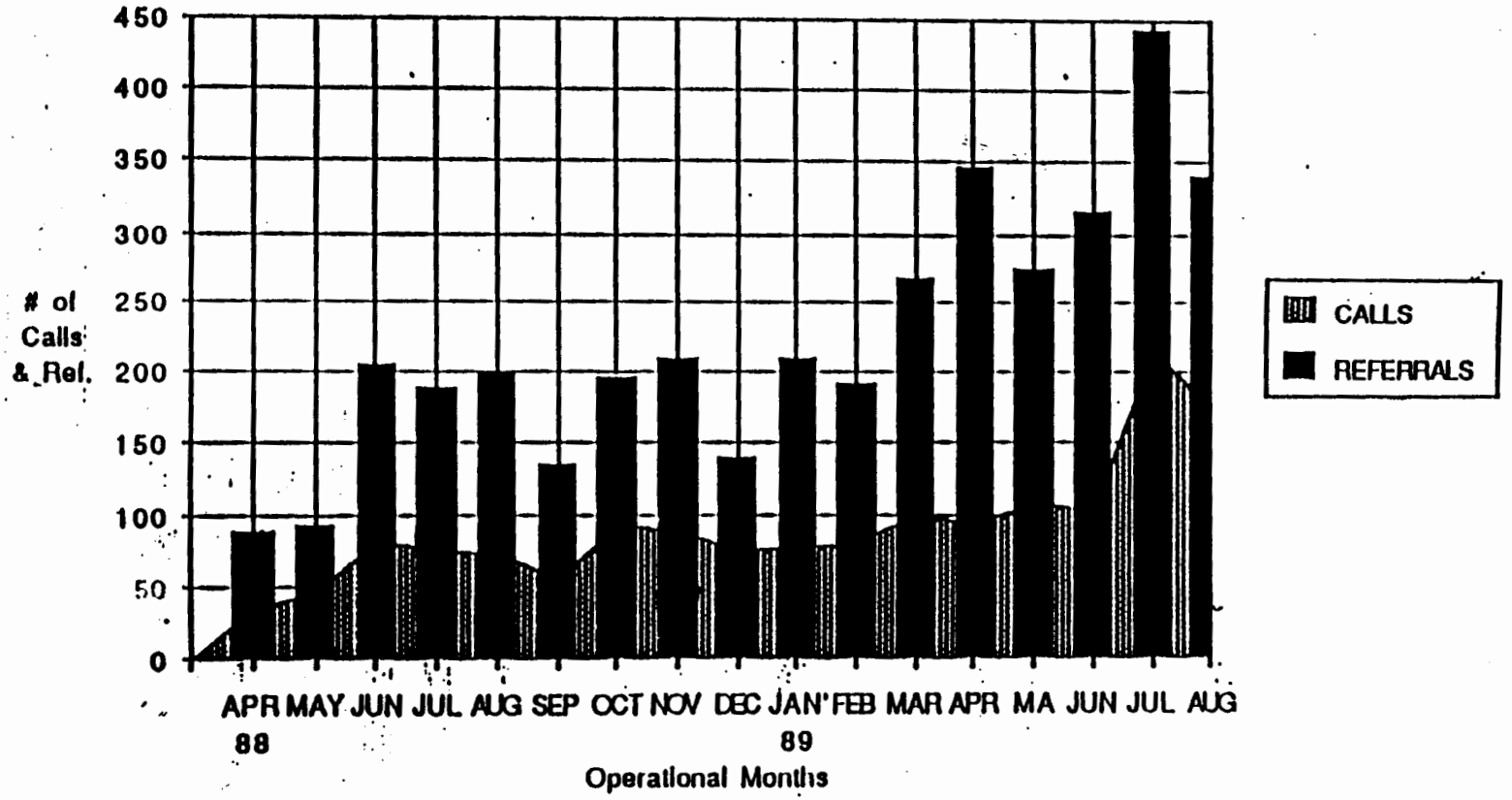
All Mayors in S.C.	255
All Chambers of Commerce	75
All Public Libraries	165
All S.C. Radio Stations	63
All S.C. Television Stations	34
All Telephone Companies	29
All Licensed Physicians	1815
All Licensed Audiologists	80
All Licensed Psychologists	269
All Licensed Speech Therapists	366
All Licensed Occupational Therapists	200

CALLS BY COUNTY
April 1988 - August 1989

ABBEVILLE	55
AIKEN	10
ALLENDALE	0
ANDERSON	60
BAMBERG	5
BARNWELL	6
BEAUFORT	42
BERKELEY	14
CALHOUN	6
CHARLESTON	128
CHEROKEE	11
CHESTER	11
CHESTERFIELD	8
CLARENDON	3
COLLETON	17
DARLINGTON	14
DILLON	5
DORCHESTER	20
EDGEFIELD	0
FAIRFIELD	6
FLORENCE	44
GEORGETOWN	18
GREENVILLE	141
GREENWOOD	24
HAMPTON	7
HORRY	84
JASPER	5
KERSHAW	14
LANCASTER	17
LAURENS	10
LEE	4
LEXINGTON	92
MARION	8
MARLBORO	3
MCCORMICK	2
NEWBERRY	10
OCONEE	18
ORANGEBURG	30
PICKENS	45
RICHLAND	411
SALUDA	6
SPARTANBURG	63
SUMTER	25
UNION	4
WILLIAMSBURG	6
YORK	35
OUT-OF-STATE	26
TOTAL	**1573**

ELDERLY ASSISTANCE LINE

Calls & Referrals Chart
for the period 4/'88 to 8/'89



ELDERLY ASSISTANCE LINE

Calls and Referrals
for the period 4/88 to 8/89

	Calls	Referrals
April (1988)	34	89
May	45	94
June	83	205
July	75	191
August	74	199
September	54	135
October	94	196
November	89	211
December	75	141
January (1989)	78	211
February	79	192
March	101	268
April	93	348
May	108	275
June	102	316
July	215	445
August	174	341
TOTAL	**1573**	**3857**

Harris - **Thank you very much. Are there any questions? I think you have a valuable service here and we do appreciate your coming and telling us about it. Next presentator is Mr. Samuel Waldrep, President of SC Gerontological Society.**

Samuel T. Waldrep, President
SC Gerontological Society
218 S. Saluda Ave.
Columbia, SC 29205

Joint Legislative Study Committee on Aging
Public Hearing - September 20, 1989

Testimony Presented by Sam Waldrep, President,
South Carolina Gerontological Society

My name is Sam Waldrep. I am here today representing the Board of Directors and members of the South Carolina Gerontological Society. The Society is dedicated to promoting advancements in gerontology in the state through education, training, advocacy and coordination. We now have five active chapters in Charleston, Greenville, Florence, Columbia, and Rock Hill.

While there are many issues facing older South Carolinians today, the Society has identified five issues to bring to your attention which are of immediate concern.

1. One of the Society's main goals has been to increase knowledge in the area of gerontology. In an effort to support this goal, it is vitally important for the State to allocate funding for research and education in the field of gerontology. The Society urges your continued support of the South Carolina Gerontology Center and increased state funding of their efforts. The Center is a consortium of the University of South Carolina, Clemson University, Lander College, Winthrop College, South Carolina State College, and the Medical University of South Carolina. An active collaboration and transfer of information between state researchers, policymakers, and direct service providers can only strengthen our efforts to insure quality care and service provision to the elderly.

2. As you are aware, there have been several initiatives related to the need for a continuum of care for older South Carolinians in need of long term care services. Unfortunately, our state has not yet established a comprehensive system of institutional and community-based services to address the needs of all persons requiring such care. The problems with our current service delivery system include: gaps in service, limitations in the amount of service that can be provided and restrictions on services based on funding sources. In addition to addressing these problems, our system would be strengthened with the addition of residential care facilities which provide a full range of housing and personal care services, more Medicaid funded nursing home beds, and more community-based services, like medical day care, in-home respite care, and private duty nursing.

3. Related to the need for a strengthened continuum of care is the necessity for services and incentives which support families in caring for the frail elderly at home. The development of more in-home services as alternatives to institutional care should be supported, and tax credits for families who provide care should be initiated. These measures would help those families who carry the emotional and financial burden of providing the majority of care to the elderly.

4. The Society acknowledges the excellent leadership provided by the General Assembly in recently allocating more funding for Medicaid-sponsored nursing home beds. However, it appears that the certificate of need process needs to be expedited so that newly allocated beds can be made available faster. We urge you to consider a complete review of the CON process to determine if it can be streamlined and revised.

5. The Society supports the study being conducted by the Health and Hospital Law Committee of the South Carolina Bar Association concerning a medical durable power of attorney and family consent statutes. Findings from this study will provide policymakers and legislators with valuable information regarding the needs of patients who have been determined to be incompetent or have no family available to make critical medical decisions.

The South Carolina Gerontological Society would appreciate your careful consideration of the matters that I have brought before you. And, in closing, I extend an invitation to each of you to attend our upcoming annual meeting on October 10th here in Columbia. The theme of this meeting reflects the Society's desire to look ahead and address a number of the issues that I have brought to your attention today.

Harris - Any questions?

Blackwell - I want to make a statement. Mr. Waldrep, in connection with your item #4, we too share your concern about streamlining the certificate of need (CON) process. However, I believe if you will make some investigation you will find that we have instructed DHEC to move immediately on any CONs for Medicaid beds. If there are any applications which in your opinion are lagging at all in that process, I'd be glad to know about it sir. They are having a hard time finding takers for the 1500 beds that we authorized. In fact, the last figure that I had was only about 285 coming on line with about 600 approved by the CON process. I don't know what figures you have. We are aware of your interest and we have instructed DHEC that they are to move immediately on any Medicaid CONs that are requested.

Waldrep - Another issue of concern involves the appeals of CON. I believe that DHEC is also addressing that.

Harris - Do we have the folks that are interested at the moment in going forward with the construction of these beds? These are questions that come up that we don't get any answers to. If you can help us on any of those, we would be happy to hear about it.

Waldrep - I think there is alot of effort on the part of the Finance Commission, DHEC, and other agencies to really recruit and promote the use of these beds because the need is so desperate out there.

Harris - Thank you very much! Any further questions? The next item is Mr. Kenneth White, State Legislative Chairman, for the AARP.

Kenneth White
676 Lake Point
Mt. Pleasant, SC 29464

(Bill Nelson - spoke)

MY NAME IS KENNETH WHITE AND I AM THE CHAIRMAN OF THHE SOUTH CAROLINA STATE LEGISLATIVE COMMITTEE OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS. MY COMMITTEE SPEAKS FOR THE SOUTH CAROLINA AARP MEMBERSHIP ON STATE LEGISLATIVE OR REGULATORY MATTERS. OUR PRINCIPAL RESPONSIBILITY IS TO PROPOSE, SUPPORT OR OPPOSE LEGISLATION OR REGULATION IN THE INTEREST OF THE STATE'S SENIOR CITIZENS. AARP HAS ABOUT 358,000 MEMBERS IN THE SOUTH CAROLINA OR 44 PERCENT OF ALL PERSONS OVER AGE 50 IN THE STATE.

SOUTH CAROLINA'S 65 AND OVER POPULATION IS GROWING RAPIDLY - TWICE AS FAST AS THE NATION AS A WHOLE. ALSO, THE POVERTY LEVEL IN THE STATE IS HIGHER THAN THE NATIONAL AVERAGE. THE HIGH POVERTY LEVEL INCREASES THE IMPACT ON THE STATE'S MEDICAID FUNDS. IN ADDITION, MORE OLDER PERSONS ARE CHOOSING TO LIVE IN SOUTH CAROLINA IN THEIR RETIREMENT YEARS. THE SOCIAL AND ECONOMIC NEEDS OF THIS OLDER POPULATION PLACES GREAT STRAINS ON THE STATE'S MODEST RESOURCES.

EVEN SO, THE MEMBERS OF THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING AND MANY OTHERS IN THE GENERAL ASSEMBLY ARE TO BE COMMENDED FOR SUPPORTING THE PASSAGE OF SIGNIFICANT LEGISLATION BENEFITTING OLDER PERSONS IN THE PAST SESSION. NEW MONIES WERE APPROPRIATED FOR MEDICAID. A BILL REGULATING CONTINUING CARE COMMUNITIES PASSED. A HEALTH INSURANCE POOL WAS AUTHORIZED FOR THOSE WHO CANNOT RECEIVE INSURANCE PROTECTION FROM PRIVATE COMPANIES BECAUSE OF ILLNESS OR INJURY. THE HOMESTEAD EXEMPTION WAS INCREASED FROM $20,000 to $25,000 FOR HOMEOWNERS OVER 65, ALTHOUGH FUNDING HAS NOT YET BEEN IMPLEMENTED. A LONG TERM CARE INSURANCE REGULATION PASSED, WHICH IMPLEMENTED A LAW PASSED IN 1988. ALSO, THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION LIBERALIZED ELIGIBILITY REQUIREMENTS FOR MEDICAID COVERAGE.

THESE AND OTHER ADVANCES IN THE FIELD OF AGING ARE FINE, BUT MORE WORK NEEDS TO BE DONE.

OUR STATE LEGISLATIVE COMMITTEE WANTS TO HELP. FOR 1990 WE HAVE IDENTIFIED SEVERAL MAJOR LEGISLATIVE PRIORITIES. THEY ARE:

1) EXPAND AND IMPROVE COORDINATION OF STATEWIDE IN-HOME AND COMMUNITY-BASED SERVICES, INCLUDING INCREASED ELIGIBILITY, TO DELAY OR PREVENT INSTITUTIONALIZATION OF THE FRAIL ELDERLY. THIS IS AN ONGOING PRIORITY FOR OUR COMMITTEE.

   THE GREATEST FEAR OF THE ELDERLY IS HAVING TO LEAVE THEIR HOMES TO ENTER A NURSING HOME. AARP FEELS THAT INCREASING THE AVAILABILITY AND AFFORDABILITY OF IN-HOME AND COMMUNITY-BASED SERVICES WILL HELP DISPEL THIS MAJOR CONCERN AND DECREASE THE NEED FOR EXPENSIVE NURSING HOME CARE. FEDERAL ELIGIBILITY STANDARDS PREVENT THE STATE FROM SERVING MORE OF THE FRAIL ELDERLY IN THEIR COMMUNITIES.

   SOUTH CAROLINA DOES HAVE A LONG-TERM CARE NETWORK IN PLACE, THROUGH THE VARIOUS PROGRAMS OF THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION, DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL AND THE COMMISSION ON AGING. UNFORTUNATELY, MANY OF THESE PROGRAMS ARE STILL UNKNOWN AMONG GREAT NUMBERS OF OLDER CITIZENS AND NOT AVAILABLE IN SOME AREAS, ESPECIALLY RURAL AREAS.

   WE RECOMMEND THE FOLLOWING:
   FIRST, BUDGET REQUESTS OF THE THREE STATE AGENCIES PERTAINING TO IN-HOME AND COMMUNITY-BASED SERVICES SHOULD BE APPROVED.

SECOND, THE STATE SHOULD ENCOURAGE THE EXPANSION OF PRIVATE SECTOR INVOLVEMENT IN APPROPRIATE WAYS.

THIRD, MORE EFFORTS SHOULD BE MADE TO EDUCATE THE PUBLIC AS TO SERVICES AVAILABLE.

FOURTH, STATES AUTHORITIES SHOULD CONTINUE IN THEIR EFFORTS TO ENCOURAGE FEDERAL AGENCIES TO RELAX ELIGIBILITY STANDARDS SO THAT MORE PEOPLE CAN BE SERVED.

2) OUR SECOND LEGISLATIVE PRIORITY IS TO ACHIEVE FUNDING FOR THE INCREASED HOMESTEAD EXEMPTION, WHICH WAS AUTHORIZED BY A 1989 LAW AT THE $25,000 LEVEL, UP FROM THE PREVIOUS $20,000 LEVEL.

WE ARE GREATLY DISAPPOINTED THAT FUNDING DID NOT ACCOMPANY PASSAGE OF THE AUTHORIZATION ACT. WE FEEL THE LEGISLATURE SHOULD FULFILL THE PROMISE IMPLICIT IN THE NEW LAW WITHOUT FURTHER DELAY.

3) OUR THIRD PRIORITY IS TO RESTRAIN THE RISE IN HEALTH CARE COSTS. THIS IS AN ONGOING PRIORITY FOR AARP, AS IT IS FOR MOST EVERY PERSON AND AGENCY WORKING IN THE HEALTH CARE FIELD. COSTS ARE NOW RISING MUCH FASTER THAN THE PACE OF A FEW SHORT YEARS AGO. THE BUSINESS WORLD IS MORE CONCERNED THAN IT EVER HAS BEEN. AND MORE VOICES ARE BEING HEARD IN MANY QUARTERS IN SUPPORT OF SOME FORM OF NATIONAL HEALTH INSURANCE TO HELP STEM HEALTH CARE INFLATION.

THIS IS A MAMMOTH PROBLEM AND ONE THAT SOUTH CAROLINA CAN HARDLY SOLVE ALONE. WE STAND READY TO SUPPORT ANY INITIATIVE THAT OFFERS SOUND PROMISE OF PROGRESS AGAINST INFLATION. IN THE MEANTIME, AARP CONTINUES TO SUPPORT THE FOLLOWING MEASURES:

FIRST, THE OPEN PUBLICATION OF HOSPITAL FEE SCHEDULES SHOULD CONTINUE. THIS DEVICE, ALREADY CURRENT IN THE STATE, CAN AID CONSUMER EDUCATION AND FOSTER COMPETITION IN THE HEALTH CARE FIELD.

SECOND, A FEASIBILITY STUDY OF AN INDEPENDENT HOSPITAL COST CONTAINMENT COMMISSION, TO SERVE THE DUAL FUNCTIONS OF CONTAINING HOSPITAL COSTS AND APPROVING CERTIFICATE OF NEED APPLICATIONS, SHOULD BE MADE.

THIRD, MORE ADEQUATE FUNDING FOR ALL COMPONENTS OF THE MEDICALLY INDIGENT ASSISTANCE ACT SHOULD BE PURSUED SO THE NEEDS OF THE MEDICALLY INDIGENT MAY BE MORE ADEQUATELY ADDRESSED, AND THE COST SHIFTING STRAIN ON HOSPITALS AND OTHER HEALTH SERVICE PROVIDERS, HEALTH CARE INSURANCE COMPANIES, AND PAYING PATIENTS MAY BE RELIEVED. IN THE PROCESS OF APPROPRIATING MONIES MORE COST CONTAINMENT MEASURES SHOULD BE COUPLED WITH THE INCREASES.

4) OUR FOURTH LEGISLATIVE PRIORITY IS TO SUPPORT EFFORTS OF STATE ENVIRONMENTAL AGENCIES IN REDUCING AIR POLLUTION AND WATER POLLUTION AND IN THE PROPER DISPOSAL OF TOXIC AND HAZARDOUS WASTE.

REAMS HAVE BEEN WRITTEN ABOUT THE DOWNWARD SPIRALS OF QUALITY IN OUR PHYSICAL ENVIRONMENT. AND MUCH HAS BEEN DONE AND IS BEING DONE TO COUNTER THIS NEGATIVE TURN. IN SOUTH CAROLINA THERE ARE SPECIAL PROBLEMS IN THE DISPOSAL OF MEDICAL AND OTHER HAZARDOUS WASTE. WE INTEND TO STRONGLY SUPPORT LEGISLATION OR REGULATION TO COMBAT WHATEVER PROBLEMS EXIST THAT THREATEN THE PUBLIC'S HEALTH.

MR. CHAIRMAN, THESE ARE OUR PRIORITIES AS WE FACE THE NEW LEGISLATIVE SEASON. OTHER ISSUES WILL ARISE IN THE DAYS AHEAD AND WE WILL ADDRESS THEM AS APPROPRIATE.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS OUR VIEWS.

Tim Cash, Director
Adult Services Division
SC Dept. of Social Servic
P.O. Box 1520
Columbia, SC 29202

Briefing Paper: Proposed Amendments to 43-29-10 et. seq. Protective Services for Developmentally Disabled and Senile Persons

Prepared by: Tim Cash, MSW, Director
Division of Adult Services
March 30, 1989

Summary: The above referenced law is commonly referred to as the Adult Protective Services Law. The proposed amendments are summarized by section as follows:

43-29-10 those to be protected are persons 18 years of age or older or emancipated minor

definitions of abuse, neglect, exploitation, and caregiver are clarified

43-29-19 An interagency/Court cooperation clause has been added.
43-29-20 Clarifies the discretion of DSS in the provision of adult protective services.
43-29-21 An inspection of the premises clause has been added.
43-29-30 Financial reimbursement/liability has been clarified.
43-29-40 "Exploitation" has been added to this section.
43-29-41 "Neglect" and "exploitation" have been added to this section.
43-29-42 Penalties remain the same.
43-29-50 "Exploitation" has been added to this section.
43-29-60 The duty of persons to report has been clarified.
43-29-70 Immunity is clarified.
43-29-80 "Exploitation" has been added to this section.
43-29-90 Procedural, constitutional, and due process safeguards have been clarified.
43-29-100 Authority to Promulgate Regulations remains unchanged. Obsolete penalties have been deleted.

Reason for Proposed Amendments:

Practical experience through administration of the Adult Protective Services Program since 1974 has shown that the aforementioned changes (specified in the text of the bill) are needed to improve program effectiveness.

Program Impact:

Clients - Amendments will ensure that clients are granted procedural safeguards during the provision of protective services.

Service Delivery System - County DSS staff will be able to obtain an inspection warrant based upon probable cause while conducting an investigation.

Policy and Procedures - Adult Services Manuals will require revision with regard to the procedural safeguards relative to due process requirements of the Courts.

Fiscal Impact - None anticipated.

Legal Impact - If the amendments to 43-29-10 et. seq. become law, the State DSS Office will promulgate regulations relative to the new procedures required by law.

Community Impact - The new amendments would allow DSS to be more responsive to reports of abuse, neglect, and exploitation (e.g. inspection warrant, court process/hearing, guardian ad litem, and clear definitions).

Political Impact - Passage of these amendments would indicate the good faith of the General Assembly and the Department of Social Services to continue cooperative efforts to address the needs of elderly and disabled persons who are victims of abuse, neglect, and exploitation.

TC:es

Senate: Lee
Attorney: Williams
Stenographer: Mills
Date: March 14, 1989
No.: 2397U

S. 625

A BILL

TO AMEND CHAPTER 29, TITLE 43, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO PROTECTIVE SERVICES FOR DEVELOPMENTALLY DISADVANTAGED AND SENILE PERSONS, SO AS TO SPECIFY THAT A "DEVELOPMENTALLY DISABLED PERSON" AND "INTERESTED PERSON" MUST BE EIGHTEEN YEARS OF AGE OR OLDER, REDEFINE "ABUSE OR NEGLECT", "PROTECTIVE SERVICES", "DEPARTMENT", AND "COURT", AND DEFINE "CAREGIVER"; REQUIRE ALL AGENCIES AND SUBDIVISIONS OF THE STATE TO COOPERATE WITH THE DEPARTMENT OF SOCIAL SERVICES AND THE FAMILY COURT IN CARRYING OUT THE RESPONSIBILITIES OF THIS CHAPTER; PROVIDE FOR THE PROVISIONS OF PROTECTIVE SERVICES BY THE DEPARTMENT; PROVIDE FOR THE CONDUCT OF AN INVESTIGATION OF A REPORT OF ABUSE, NEGLECT, OR EXPLOITATION; PROVIDE FOR THE PAYMENT FOR PLACEMENT OF INDIVIDUALS IN APPROPRIATE HOMES OR INSTITUTIONS AND FOR THE PAYMENT FOR THIS PLACEMENT; PROVIDE IMMUNITY FROM CIVIL LIABILITY FOR A PERSON WHO LODGES A COMPLAINT IN GOOD FAITH WHEN HE SUSPECTS ABUSE OR MALTREATMENT OF PERSONS; AUTHORIZE THE COUNTY DEPARTMENT OF SOCIAL SERVICES TO PROVIDE PROTECTIVE SERVICES FOR PERSONS ALLEGED TO HAVE BEEN ABUSED, NEGLECTED, OR EXPLOITED PENDING TRIAL AND FOR THE CONTINUED PROVISION OF SERVICE IF THAT CONVICTION RESULTS IN THE CASE; PROVIDE FOR THE PROVISION OF BASIC NEEDS FOR PERSONS WHO ARE UNABLE TO CARE FOR THEMSELVES BECAUSE OF FINANCIAL RESOURCES OR PHYSICAL OR MENTAL

DISABILITIES; AND AUTHORIZE THE DEPARTMENT TO PROMULGATE REGULATIONS TO PROVIDE PROCEDURES FOR COUNTY DEPARTMENTS IN THE EXERCISE OF ITS DUTIES AND RESPONSIBILITIES UNDER THIS CHAPTER.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Chapter 29, Title 43, of the 1976 Code is amended to read:

"CHAPTER 29

Protective Services for Developmentally Disabled and Senile Persons

Section 43-29-10. As used in this chapter:

(1) 'Developmentally disabled person' means any individual eighteen years of age or older, or an emancipated minor having a disability attributable to mental retardation, cerebral palsy, epilepsy, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals, which has continued or can be expected to continue indefinitely and substantially impairs the individual from adequately providing for his own care or custody.

(2) 'Interested person' means any adult relative or friend of a person eighteen years of age or older to be protected under this chapter; or any official or representative of a public or private agency, corporation or association concerned with his welfare.

(3) 'Other like incapacities' means those conditions incurred at any age which are the result of accident, mental or physical illness, producing a condition which substantially impairs an individual from adequately providing for his own care or custody.

(4) 'Senility' means organic brain damage caused by advanced age or other physical illness in connection therewith to the extent that the

person eighteen years of age or older so afflicted is substantially impaired in his ability to adequately provide for his own care or custody.

(5) "Abuse or neglect" means actual physical abuse, unreasonable confinement by anyone or, when such person is under the care and control of another, a failure to provide for basic needs such as food, shelter, clothing, medical care or other necessities within the financial capability of the person exercising such care and control. Provided, however, no person shall be deemed to be abused or neglected for the sole reason he is being furnished nonmedical remedial treatment by spiritual means through prayer alone which he has practiced in accordance with the tenets and practice of a recognized church or religious denomination, in lieu of medical treatment.

'Caregiver' means an individual adult who has the responsibility for the care of the adult as a result of family relationship or who has assumed the responsibility for the care of the adult voluntarily or by contract.

(6) "Exploitation" means an unjust or improper use of another person for one's own profit or advantage.

'Abuse' means the wilful infliction of physical pain, injury, threats causing mental anguish, unreasonable confinement by another, or the wilful deprivation by a caregiver of necessities of life such as food, clothing, shelter, or medical care.

(7) "Protective services" means those services whose objective is to protect an incapacitated person from himself and from others. They shall consist of evaluation of the need for service and mobilization on the person's behalf of appropriate existing services and shall include, but shall not be limited to, arrangements for appropriate living quarters, obtaining financial benefits to which the person is entitled, securing medical services and supplies and legal services in those situations where exploitation, prevention of injury,

~~protection of the person and his property and serving the necessities or amenities of life are at issue.~~

'Neglect' means a failure to provide for basic needs such as food, clothing, shelter, medical care, or other necessities. This includes self-neglect of any senile, mentally ill, mentally retarded, developmentally disabled, or of any person suffering from other like incapacities and also includes neglect when under the care and control of another who fails to provide these needs, even though they are within the financial capability of the person exercising this care and control. No person is considered to be abused or neglected for the sole reason he is being furnished nonmedical remedial treatment by spiritual means through prayer alone which he has practiced in accordance with the tenets and practices of a recognized church or religious denomination, in lieu of medical treatment.

~~(8) "Department" means the South Carolina Department of Social Services which has been designated as the single State agency for services under the Social Security Act.~~

'Exploitation' means the wilful, improper, unjust, or illegal use or management of any senile, mentally ill, mentally retarded, or developmentally disabled person, or of any person suffering from other like incapacities or of the person's funds, assets, resources, property, power of attorney, or of guardianship for one's own profit or advantage or the profit or advantage of another person.

~~(9) "Court" means family court or other court exercising such jurisdiction.~~

'Protective services' means those services whose objective is to protect an incapacitated person from himself and from others. They consist of evaluation of the need for service and mobilization on the person's behalf of appropriate existing services and include, but are not limited to, arrangements for appropriate living quarters, obtaining financial benefits to

which the person is entitled, securing medical services and supplies, and legal services in those situations where exploitation, prevention of injury, protection of the person and his property, and providing the necessities or amenities of life are at issue.

(10) 'Department' means the South Carolina Department of Social Services.

(11) 'Court' means family court or other court exercising the jurisdiction of family court.

Section 43-29-15. All agencies and subdivisions of the State shall cooperate with the Department of Social Services and the family court in the carrying out of the responsibilities under this chapter.

Section 43-29-20. ~~(1)~~ (A) The department may provide protective services under any of the following conditions:

~~(a)~~(1) The person who needs or believes he needs protective service may seek ~~such~~ the service.

~~(b)~~(2) Any interested person or caregiver may request service on behalf of a person in need of services.

~~(c)~~(3) The department may provide services on behalf of any person in need of protective services.

~~(d)~~(4) The court may request ~~such~~ the services.

~~(2)~~(B) All protective services ~~shall be~~ are voluntary unless ordered by the court or requested by a parent, guardian, or friend or requested by an individual or agency having a responsibility to render care or offer services to the protected adult. The provision of all protective services is within the discretion of the Department of Social Services, unless court ordered.

(3) No person may interfere with the provision of protective services if the adult consents to these services or the court has ordered these services.

(4) The department may request from the family court an order enjoining the caregiver or any other person from interfering with the provision of protective services to the adult.

Section 43-29-25. In conducting an investigation of a report of abuse, neglect, or exploitation, if the facts warrant, the agency investigator may petition the family court of the appropriate judicial circuit for a warrant to inspect the premises and condition of the adult subject of the report. The court shall issue the inspection warrant upon probable cause to believe the adult has been abused, neglected, or exploited, as defined by this chapter.

After issuance of the inspection warrant, the representative of the department may be accompanied by a law enforcement officer to the premises. The department additionally shall take photographs of the premises and of any visible areas of trauma on any adult for whom a report has been made, and may authorize the taking of x-ray photographs in the event that the action is considered appropriate for either diagnostic or investigative purposes.

Section 43-29-30. ~~(1)~~(A) The department, an agency, or a guardian may request the family court or other court exercising jurisdiction to provide protective placement of an individual for purposes of care or custody. No protective placement may be ordered unless there is a determination by the court that the individual is unable to provide for his own protection from abuse or neglect by another or himself. The court shall appoint a guardian ad litem to insure that the best interest of the person is served.

~~(2)~~(B) The court shall give preference in making a determination to the least drastic alternative considered to be proper under the circumstances, including a preference for noninstitutional care wherever possible. Before ordering the protective placement of any

individual, the court shall direct a comprehensive evaluation of the person in need of services, if ~~such an~~ the evaluation has not already been made. The court may utilize available multidisciplinary resources in the community in determining the need for placement. The department shall cooperate with the court in securing available resources. A copy of the comprehensive evaluation ~~shall~~ must be provided to the guardian or to the guardian ad litem or attorney of the individual. The court obtaining the evaluation shall request appropriate information which ~~shall~~ must include at least the following:

~~(a)~~(1) The address of the place where the person is residing and the person or agency who is providing services at present, if any;

~~(b)~~(2) A resume of professional treatment and services provided to the person by the department or agency, if any, in connection with the problem creating the need for placement;

~~(c)~~(3) A medical, psychological, social, vocational, and educational evaluation and review, where necessary, and any recommendations for or against maintenance of partial rights.

~~(3)~~(C) The department shall make an evaluation and submit a written report at least once every six months covering the physical, mental, and social condition of each person for whom it is acting and shall recommend less drastic placement or discharge where appropriate. Any record of the department or other agency pertaining to ~~such~~ a this person ~~shall~~ must not be open for public inspection. Information ~~therein~~ in it ~~shall~~ may not be disclosed publicly in such a manner as to identify individuals, but may be made available on application for cause to persons approved by the director of the department or the court.

~~(4)~~(D) Reasonable expenses for the evaluations required by this chapter ~~shall~~ must be assumed by the department. The department shall seek appropriate Federal reimbursement for ~~such~~ these evaluations.

~~(5)~~(E) ~~Prior to discharge from the care or custody of the department, the department shall review the need for continued protective service, including the appointment of a guardian or limited guardian. Upon recommendation by the department the court may appoint such guardian.~~ The court may order that the adult's financial records be made available at a certain day and time for inspection by the court, solicitor, or other legal representative of the agency.

~~(6)~~(F) Placement may be made to ~~such~~ facilities such as nursing homes, boarding homes, personal medical institutions, foster care services, or to other appropriate facilities.

(1) Payment for this placement must be made from the resources of the person being placed, if available.

(2) If payment is made by the department, reimbursement must be requested from the available resources of the person or from the estate if the adult become deceased.

(3) The department may request an order from the appropriate court for the purpose of payment or reimbursement.

(G) Prior to discharge from the care or custody of the department, the department shall review the need for continued protective service, including the appointment of a guardian or limited guardian. Upon recommendation by the department, the court may appoint this guardian.

~~(7)~~(H) Any person may request voluntary protective placement under this chapter. No civil rights are relinquished as a result of ~~such~~ this placement.

Section 43-29-40. It ~~shall be~~ is unlawful for any person to abuse, neglect, or exploit any senile, mentally ill, developmentally disabled, or mentally retarded person or any person suffering from other like incapacities, who is incapable of caring for or managing his own affairs. This ~~shall~~ does not apply to

altercations or acts of assault between persons protected by this section.

Charges of ~~such~~ this abuse, neglect, or exploitation may be initiated upon complaints of private individuals or as a result of investigations by any state agency or public official or on the direct initiative of a county solicitor or law enforcement official.

~~Section 43-29-41. Notwithstanding the provisions of § 43-29-100, any person who violates the provisions of § 43-29-40 shall be deemed guilty of a misdemeanor and upon conviction shall be fined not less than five hundred dollars nor more than five thousand dollars or be imprisoned for not less than ninety days nor more than five years.~~

~~Section 43-29-42. Notwithstanding the provisions of § 43-29-100, any person who fails to report alleged abuse or maltreatment of persons protected by § 43-29-40 shall be charged as an accessory after the fact and shall be deemed guilty of a misdemeanor and upon conviction shall be fined not less than one hundred dollars nor more than one thousand dollars or be imprisoned for not more than six months.~~

Section 43-29-50. All practitioners of the healing arts having reasonable cause to believe that any person who is senile, developmentally disabled, or mentally ill has been subjected to physical abuse, neglect, or exploitation by another or himself shall report or cause a report to be made as ~~follows~~ in accordance with the provisions of Section 43-29-60.

~~(a) An oral report, by telephone or otherwise, shall be made immediately to the County Department of Social Services or to the county sheriff's office or chief county law enforcement officer in the county where such person resides or is found.~~

~~(b) Within three days following such oral~~

~~report, an investigation shall be made by the County Department of Social Services or sheriff's office or chief county law enforcement officer and a written report prepared which will include the following:~~

~~(1) Name, age and address of such person;~~

~~(2) Nature and extent of injury suffered by such person, including any evidence of previous injury;~~

~~(3) Any other facts or circumstances known to the reporter which may aid in the future determination of guilt.~~

~~All reports prepared by the county sheriff's department or chief county law enforcement officer shall be forwarded to the County Department of Social Services within twenty-four hours and vice versa.~~

Section 43-29-60. ~~Any person or agency that lodges such a complaint in good faith shall not be subject to prosecution or civil liability for such action.~~ It is the duty of a person to report suspected cases of abuse or maltreatment of a person protected by Section 43-29-40 as follows:

(1) An oral report, by telephone or otherwise, must be made immediately to the county Department of Social Services or to the county sheriff's office or chief county law enforcement officer in the county where the person resides or is found.

(2) Within three days following the oral report, an investigation must be made by the county Department of Social Services or sheriff's office or chief county law enforcement officer and a written report prepared which must include the following:

(a) name, age, and address of the person;

(b) nature and extent of injury suffered by the person, including any evidence of previous injury;

(3) any other facts or circumstances known to the reporter which may aid in the future determination of guilt.

All reports prepared by the county sheriff's department or chief county law enforcement officer must be forwarded to the county Department of Social Services within twenty-four hours and vice versa.

Section 43-29-70. ~~Pending trial of any case arising from an alleged violation of this chapter, the County Department of Social Services is authorized to provide for protective services for the person alleged to have been abused, neglected or exploited. If a conviction results in the case, the agency may continue such services in a private or public institution or foster home, boarding home, nursing home or other similar facility until suitable permanent arrangements, as per § 43-29-80, can be made for the person concerned. All resources of the agency shall be utilized to insure that the abused, neglected or exploited person shall not be subject to such further abuse, neglect or exploitation. The court in the county shall, upon motion of the Department of Social Services, provide by order such legal protection as the court shall determine necessary to prevent such further treatment of the person concerned and provide for his care and custody.~~ A person or agency that lodges a complaint as provided in Section 43-29-60 in good faith is not subject to prosecution or civil liability for the action. A person who reports pursuant to this chapter or who participates in judicial proceedings resulting from it, acting in good faith, is immune from civil and criminal liability which might otherwise result by reason of these actions. In all these civil or criminal proceedings good faith is rebuttably presumed.

Section 43-29-80. ~~When a County Department of Social Services finds a senile, developmentally disabled or mentally ill person who is unable because of financial resources or physical or mental disabilities to provide for his basic~~

needs for shelter, food, clothing and health care, the agency may (1) immediately provide care to the extent the person is not taken into custody or removed from his home or (2) petition the court for a temporary order authorizing the agency to take custody of and provide care for such person until suitable permanent arrangements can be made which will insure the protection of the health and safety of the person concerned. Upon a determination of the court that such agency care is urgently and immediately necessary and upon appropriate order of the court, the agency shall be authorized to assume custody and place such person in a foster home, boarding home, nursing home or other similar facility for a period not to exceed ninety days. At the proceeding to obtain the necessary order, any relative or other interested person may appear to oppose or join in the petition of the agency, but notice to such relative or interested person is not required. During the period of agency custody, all resources of the social service agency shall be utilized to provide a permanent suitable environment for the persons concerned. Before expiration of the ninety day period, a proper hearing shall be held, as per § 43-29-30 to determine if further care is required. (A) Pending trial of any case arising from an alleged violation of this chapter, the county Department of Social Services is authorized to provide for protective services for the person alleged to have been abused, neglected, or exploited.

(B) If a conviction results in the case, the agency may continue the services in a private or public institution or foster home, boarding home, nursing home, or other similar facility until suitable permanent arrangements, as provided in Section 43-29-90, are made for the person concerned. All resources of the agency must be utilized to insure that the abused, neglected, or exploited person is not subject to further abuse, neglect, or exploitation. The

court in the county, upon motion of the Department of Social Services, shall provide by order such legal protection as the court determines necessary to prevent further mistreatment of the person concerned and provide for his care and custody.

Section 43-29-90. ~~The State Department of Social Services shall promulgate regulations to provide procedures for County Departments of Social Services in the exercise of their duties and responsibilities under this chapter.~~ When a county Department of Social Services finds a senile, developmentally disabled, mentally ill, mentally retarded person, or person suffering from other similar incapacities who is unable because of financial resources or physical or mental disabilities to provide for his basic needs for shelter, food, clothing, and health care, the agency may:

(1) immediately provide care to the extent the person is not taken into custody or removed from his home; or

(2) petition the court for a temporary order authorizing the agency to take custody of and provide care for the person until suitable permanent arrangements are made which insures the protection of the health and safety of the person concerned. The preliminary hearing on this petition must occur within ten days of its filing. The proceeding may be further expedited by the court to any extent necessary to protect the interest of the adult in question. The court shall consider the appointment of a guardian ad litem at this preliminary hearing. At the preliminary hearing the court shall consider, based upon the department's evidence, whether there is probable cause to issue a temporary order for protective placement. Upon a determination of the court that the action is urgently and immediately necessary and upon appropriate order of the court, the agency is authorized to assume custody and place the person in a foster home, boarding home, nursing

home, or other similar facility. Before expiration of forty days following the preliminary hearing, a proper hearing must be held as provided in Section 43-29-30. At the proceedings to obtain the necessary orders, any relative or other interested person may appear to oppose or join in the petition of the agency, but notice to the relative or interested person is not required. During the period of agency custody, all resources of the social service agency must be utilized to provide a permanent suitable environment for the persons concerned.

Section 43-29-100. ~~Any person who violates the provisions of this chapter shall be deemed guilty of a misdemeanor and upon conviction shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than five hundred dollars or imprisoned for not more than ninety days.~~ The Department of Social Services shall promulgate regulations to provide procedures for county Departments of Social Services in the exercise of their duties and responsibilities under this chapter.

Section 43-29-110. (A) A person who violates the provisions of Section 43-29-40 is guilty of a misdemeanor and, upon conviction, must be fined not less than five hundred dollars nor more than five thousand dollars or be imprisoned for not less than ninety days nor more than five years.

(B) A person who has knowledge of and fails to report alleged abuse or maltreatment of persons protected by Section 43-29-40 must be charged as an accessory after the fact and is guilty of a misdemeanor and, upon conviction, must be fined not less than one hundred dollars nor more than one thousand dollars or be imprisoned for not more than six months."

SECTION 2. This act takes effect upon approval by the Governor.

Representative Harriet Keyserling
P.O. Box 1108
Beaufort, SC 29901

REMARKS BY HARRIET KEYSERLING September 1989

TO JOINT LEGISLATIVE COMMITTEE ON AGING

Every state in the country now has some sort of legislated property tax relief for poor, elderly or disabled home owners. In 1965 only six states had a relief program. In 1970 about half of all states had such a program. By 1975 every state had a property tax relief program.

Property tax relief programs may take many forms, the most common of which are the circuit breaker and the homestead exemption. The circuit breaker program compares the income tax liability and the property tax liability of a taxpayer. When the property tax liability exceeds a certain level with respect to the income tax liability, a portion of the income tax is refunded to the taxpayer. When an individual suffers from tax overload relative to his income, the circuit is broken and relief occurs, much like a circuit breaker protects a home from electrical overload.

The homestead exemption targets groups of eligible persons. When a person meets certain eligibility requirements (is elderly, disabled, blind) some or all of his real property may be exempted from taxation.

The two programs, circuit breaker and homestead exemption, are not mutually exclusive. In 1985, 31 states had a circuit breaker, 46 had a homestead exemption and 29 states had a combination. One of the most common combination forms was a homestead exemption for the elderly whose income was below some predetermined level. This is what I and several other legislators proposed last year and I would like to explain why, in the hope we can gain your support.

The State reimburses counties for taxes forgone under the homestead provisions. The future of property tax relief is uncertain as the cost to the State for homestead programs escalates. In 1972, when the homestead exemption began, the State spent $3.5 million. As the threshold was raised over the years, the cost grew. This year the State spent over $29 million.

In 1985, there were approximately 346,000 South Carolinians age 65 or over. That number is expected to be 632,700 in the year 2010, an 83% increase in twenty-five years. This growth is attributed to a longer life span and a growing in-migration of retirees.

In addition, a growing number of South Carolinians aged 65 and over own their own homes. In 1970, 14% of the elderly owned their homes; in 1980 over 49%. It is expected soon South Carolina will reach the national 75% as more well-to-do retirees move into the State.

To further increase the costs of homestead exemption rebates by the State to the counties, the values of property have greatly increased with uniform property re-assessment across the State.

As the tax burden shifts to the young from the old, there will be more resistance to increasing the homestead exemptions. So we must look for innovative ways to protect those who need the protection, those who cannot pay growing property taxes with their fixed and limited incomes. That is why I am looking at the circuit breaker, in combination with the homested exemption. I along with Rep. Tim Rogers, Senator Waddell and others have worked on many formulas, trying not to reduce present benefits while factoring income in. But that took more State funds than we could find. We will keep searching to find a do-able solution, which may reduce exemptions for high income elderly, but which will hurt no one.

Harris - Thank you very much, Len. We looked at this rather extensively last year. Did you bring the impact statement along with you?

Marini - No sir. I can get that for you.

Harris - We have it. Thank you.

Lourie - Does your circuit breaker legislation deal with renters or just property owners?

Marini - I'm a reader today.

Blackwell - Just property owners, Senator.

Harris - Thank you! Mr. James Rider, citizen of Georgetown county.

James Rider
40 Inlet Oaks Village
P.O. Box 1628
Murrells Inlet, SC 29576

Rep. Harris, committee members, ladies and gentlemen:

A year ago, I spoke to this very same committee. As a result, two bills were forthcoming in the 1989 Legislative Session, H-3594 and S-578. We appreciate the work that the committee has done to date but both bills avoid the main thrust of my remarks last year - security. In both bills some short term security is suggested such as length of leases; eviction without good cause. But at this time in life, the senior has the right to ask, "Where will I be tomorrow? I'd like today and tomorrow to be secure."

When young we change schools, move away from home, career goals - tomorrow is a long time coming. But for seniors, tomorrow is now. And the others who find mobile home living suits their needs - young marrieds in, perhaps, their first home; enlisted military; the working poor; and just the poor - certainly a sense of security would be a leg up in their lives.

In mobile homeparks security comes in the form of:

5th point to be made here - please note

1. Long term up to life-time leases
2. First offer to park's tenants if park is for sale and the owner has a buyer and a bona fide selling price.
3. If a park is sold after the tenants fail to purchase same, and the park is to be used for other purposes (than a mobile home park), the new owner is to purchase at 80% of present replacement value all homes that the owners for many and varied reasons can not or do not want to move. See notes following.

(pay) 4. → owner of park (new/old) to pay all costs of taking down - transporting - re-setting up at new location

5. Unconscionable rent increases - this explains itself along with a proviso found in the Senate bills Subarticle IV, General Provisions, Section 27-42-320 (E) p.5 regarding take backs.

Back to point #3 above - it is costly to move a mobile home. Perhaps the park's new owner(s) according to Law, would pay for the moves. Some mobiles can't be moved because other parks do not want them. They are too old; too small. Some parks only want 14' or wider; some only want double-wides; some only will take you if you buy the mobile that you will live in on their land from them; some mobiles and their additions would be irreparably damaged in a move attempt.

Why not buy own land - no restrictions. The nearness of neighbors - for companionship, for safety, will be found in a park. Living by oneself on an isolated piece of land is not the wisest choice for an elderly person all alone. Shouldn't any person - young; military; poor; old have the comfort and security of having neighbor-

Where do the present bills go from here - if additions can be made to them, I do not know? If additions can be added, I'd certainly like to see, as well as others that I've spoken to, that all four of my points be added to the House bill, and three points, it already includes point 4, to the Senate bill.

I have purposely kept this presentation brief so that the areas deemed absolutely needed will not be lost in too long a dialog.

With appreciation,

James R. Rider
Murrells Inlet, South Carolina
Phone: 1-803-651-6016

Harris - Thank you very much, Mr. Rider. We appreciate you coming like Mr. Blackwell says the bill process is extremely slow sometimes at the legislative level.

Rider - I appreciate that.

Harris - We appreciate you coming back and giving us this information.

Blackwell - Has the bill been marked-up?

Barron - No, it has not.

Blackwell - The committee process would be a good time for someone like yourself to appear before them and make suggestions as to what needs to be done. We might ask staff just to make Mr. Rider's interest known to Labor, Commerce, and Industry.

Harris - That's a good suggestion. We will follow through on that Mr. Rider. Thank you again. The next presentator is Dr. James Califf, Executive Director, of Horry County Council on Aging, Inc.

Dr. James I. Califf, Executive Director
Horry County Council on Aging, Inc.
Box 1693
Conway, SC 29526

COPY

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October 4, 1989

ADDRESS TO JOINT LEGISLATIVE COMMITTEE ON AGING - 9/20/89

Dr. James I. Califf 12:20 - 12:30

Thank you for the opportunity to address you in regard to senior needs. I am Dr. James I. Califf, executive director of the Horry County Council on Aging, Inc. I'm here to represent the senior adults of Horry County - the S.C. County with the largest land area east of the Mississippi. I do want you to know that we support the efforts of Mr. Rider, and his group to obtain legislation that carefully spells out the contractual relationships between a mobile home park owner and the tenants. The 1980 census showed us 16,000 persons 60 and over. Many live in Mobile Home Parks in the South Strand area. The 1990 census is expected to show a growth to at least 21,000 60 + seniors.

The large geographic area and the number of senior adults we have to serve are part of the problem we have in producing services under our present system. I'm here today to recommend that the state legislature create a state mandated system for providing services - such a system to be modeled after the State Mental Retardation Organization.

In the present set up as a private - non profit corporation which is part of loose agency network, senior services are optional. To get tax exemption for our property and vans I have to make application to the S.C. Tax Commission because we are not a state or county agency. We can't purchase at state gasoline prices because we are not governmental; to be able to do so would double our ability to produce much needed transportation services. For the last 3 years, the Horry County Administrator has recommended that all supplemental agencies such as ours get no funding because we're "optional". For two years we received 27,000; this year $43,500. The Horry County Dog Pound got $55,000 last year.

Being "optional" produces instability; no one knows if the program will be funded the next year. Such instability leads to a loss of people who are willing to work at producing services for senior adults. A second by-product of the instability is the lack of educational programs to train people to work in senior service delivery.

In the spring of 1989, the S.C. Commission released a study that indicated Horry County had 7500-8500 moderately to severely impaired seniors 65 and over. The combination of public and private agencies is unable to provide in-home services and home delivered meals. We lack funds to deal with the problem because we're an option at state and county levels of government.

In May of 1988, the Waccamaw Regional Planning Council disbanded its agency network. It didn't want to be involved in the hassle of providing services in addition to the $25,000 needed to match funds provided. It did so because we were an "optional" service. We haven't had a area agency since then but we haven't really missed it. For 10 years, Horry County with a population of $16,000 60 + persons received the same funds as Williamsburg and Georgetown Counties which had approximately 5000 each.

At 11:30 A.M. yesterday I received a call from a lady in Garden City who needed to go to the Grand Strand Hospital to be there by 2:15 P.M. I tried to get a taxi but the charge would have been $56.00. I finally got a volunteer to go. We lack the funds needed to provide much needed transportation.

I point this out because I feel a state legislated system such as the S.C.M.R.D. would provide the stability we need and help us be assured of not being considered as "optional". I would like to recommend that the state legislature create such a system.

Harris - Thank you. Are there any questions?

Waldrop - Dr. Califf, did you not try to attempt to join the state agency on Council on Aging? Have you ever attempted that?

Califf - I'm sorry I didn't hear you.

Waldrop - Have you ever attempted to join the State Council on Aging?

Califf - I don't know whether I really understand that or not.

Lourie - Why aren't you affiliated with a State agency?

Califf - We have a relationship with the SCCOA if that's what you are talking about. We are funded through federal or state funds that we received from them but we aren't regarded as a state agency because we are private non-profit that was created in 1979 for the purpose of receiving federal, state, and local funds from private donations for the production of services as such we have no existence as a state agency. We can't claim that we are.

Harris - You do get some funding from the SCCOA.

Califf - Yes sir. We get most of our funding from SCCOA but in 1988 the Waccamaw Regional Planning Council decided to do away with the Area Agency because it was an option. It didn't want to put up the $25,000 and it didn't want to deal with the hassle that went with the Aging Unit and so they dropped us. We have a direct relationship with the SCCOA. For 10 years they have given us one-third of the money that was designated for the Waccamaw Region. Even though we have 21,000 people in Georgetown and Williamsburg counties only have 5000 people, we have never received more than one-third of the share of funds.

Waldrop - What you want right now the way I gather it is to be a self organization with regional offices. But you do receive funds - federal and state?

Califf - Yes, we do!

Harris - Thank you, Doctor! We appreciate your coming. This completes our agenda until after lunch which is at 1:30 p.m. We will try to convene on time and get into the afternoon portion of the agenda.

Gwen Power, Deputy Executive Director
HHSFC
1801 Main St., P.O. Box 8206
Columbia, SC 29202-8206

STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

TESTIMONY

Presented to the State of South Carolina
Joint Legislative Committee on Aging
Public Hearing
September 20, 1989
by
Gwen Power
Deputy Executive Director
Office of Programs

Representative Pat Harris and members of the Joint Legislative Committee on Aging, on behalf of the State Health and Human Services Finance Commission I'd like to thank you for your support of the programs that are administered by the Finance Commission. As you are aware many of these programs play an important role in the State's efforts to meet the needs of the elderly.

The thrust of the Medicaid Program's long term care efforts in 1989 has been to improve access to care by increasing the availability of services and extending Medicaid eligibility to additional populations not previously covered.

Medicaid's expansions in eligibility which effect long term care include the following areas:

1. Qualified Medicare Beneficiaries (QMB)- The Catastrophic Act requires states to pay premiums, coinsurance, and deductibles for all persons covered under Medicare Part A with income under 100% of poverty ($5,980 per yr. for an individual or $8020 per yr. for a couple) and resources under $4,000 for an individual and $6,000 for a couple;

2. Aged, Blind, or Disabled Under 100% of Poverty- Effective October 1, 1989, aged (+65), blind or disabled persons who do not have Part A Medicare, but have an income below 100% of poverty, with resources below $4,000 for an individual or $6,000 for a couple, may also be eligible for Medicaid. This category is similar to QMB except that since these persons do not have Part A Medicare, they must be aged, blind, or disabled according to SSI rules to meet the State's eligibility criteria;

3. Medically Needy- A program for the Medically Needy is targeted to begin March, 1990. This will cover individuals who are aged, blind, or disabled according to SSI eligibility rules and who incur substantial medical expenses which cause their income to be reduced to a certain level. The income level, budget periods and length of eligibility will be finalized later this year;

4. Spousal Impoverishment- This provision will be effective in October, 1989. This change allows a community spouse of an institutionalized individual to keep up to $1500 per month in income and the couple to keep up to $60,000 in combined resources;

As you are aware, access to nursing home care for the Medicaid eligible elderly has become one of South Carolina's most critical problems.

1. The State Health and Human Services Finance Commission (SHHSFC) will now reimburse hospitals for patients in swing beds who meet the intermediate level of care criteria.

2. Hospitals which have between 50 and 100 beds are now eligible to participate in the swing bed program.

3. A program to allow hospitals to be reimbursed for administrative days through the Medicaid program has been initiated. When a nursing home bed is not immediately available, this change allows the hospital to be reimbursed at the average nursing home rate for Medicaid eligible persons who meet nursing home level of care requirements but no longer need acute care.

4. Nursing home rates have been increased across the board in the area of nursing services as well as increased general rates in order to make it more attractive for a nursing home to serve a Medicaid recipient.

Home and community-based services are an integral part of the State's Medicaid long term care program. The changes made in home and community-based services to improve access include the following:

1. CLTC Waiver- The CLTC waiver is being amended to raise the cap on the number of persons that can be served. Several new services are being explored for FY 90-91 which include home modifications and supplies, in-home respite care, and hospice care; and

2. Personal Care Aide Service (PCA)- PCA services are being removed from the CLTC waivers and will be offered as an optional service under the State's Medicaid Plan. All PCA services will be prior-authorized according to the needs of the individual.

   PCA services will continue to be available for persons who meet the Medicaid skilled or intermediate level of care criteria.

Persons who do not meet the skilled or intermediate level of care criteria, but need assistance with three Activities of Daily Living (bathing, dressing, walking, incontinence care, mobility or transferring) will be able to receive PCA services beginning 1/1/90 if funds are available. As funds become available in the future SHHSFC would like to cover persons requiring assistance with 2 or more Activities of Daily Living.

We would like to request that the Joint Legislative Committee on Aging consider drafting and supporting legislation which would require licensure for providers of Personal Care Aide Services. Currently any group can offer Personal Care Aide Services for private pay citizens without having to meet any standards unless they are also serving Medicaid clients. This is a service that is rapidly expanding which does not have any standards to protect the elderly or disabled recipient of the service.

We would also like for you to consider supporting tax incentives for families who provide in home care for frail elderly persons who might otherwise need nursing home care.

Thank you again for the support you have given to our agency in the past. We request your continued support as we strive to improve and expand services to meet the needs of the frail elderly citizens of South Carolina.

Harris - Thank you very much. Any questions of Ms. Power? Gwen, would you work with our staff on this proposed legislation to see that we get something that will adequately address your needs. That's not an easy job but if you will work with Keller and the staff on that, we would appreciate that.

Power - We would be delighted.

Harris - Thank you very much. Mr. Jim Manning, Chairman of Education Legislation Action Network.

Jim Manning, ACSW, Chair
SC NASW
P.O. Box 5008
Columbia, SC 29250

NASW

SOUTH CAROLINA STATE CHAPTER NATIONAL ASSOCIATION OF SOCIAL WORKERS
P.O. Box 5008 • Columbia, South Carolina 29250 • (803) 256-8406

TESTIMONY AS PRESENTED 9/20/89 AT THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING PUBLIC HEARING

Larry and I played together even before we entered Kindergarten. We rode together to our High School Graduation Ceremony. We were each other's best man when we married. Recently, Larry's mother passed away and it was a difficult time for the both Larry and me. He lives on the West Coast so our interactions are stifled by the distance. I phoned Larry about two weeks after the funeral to see how he was doing. He was outraged. The first thing out of his mouth after he heard my voice was, "I've been dealing with the business matters related to my mother's death and I've never be this upset in my life. Traveling to other countries on business, I see how they value people as they age but it seems that here the older you get the more you get ripped off." LARRY IS RIGHT! We must accept this truth and set a course to rectify it's reality.

Since 1900, the percentage of the U. S. population 65 years and older has more than doubled. Today, older Americans constitute roughly 10 percent of the population. By the year 2000, this proportion is expected to reach one in eight. As a group, older Americans often have needs and problems related to their social situations, economic conditions and physical limitations and subsequently comprise one of the highest at-risk populations in the nation.

Our society has failed to address adequately the needs of older Americans. Additionally, social work has historically failed to recognize it's unique contribution among the professions to the improvement of the quality of life for older Americans. It is for these reasons that social workers need to collaborate with Legislators to address several areas in regard to older Americans and specifically older South Carolinians.

- **INVOLVEMENT OF THE ELDERLY.** Older persons should be involved significantly in the planning, policy development and administration of programs.

- **ECONOMIC SECURITY.** The aim, as declared by the 1971 White House Conference on Aging, should be a minimum income standard for the elderly, which will provide sufficient security in terms of economic needs.

- **EMPLOYMENT AND RETIREMENT.** Aging persons should not be discriminated against or exploited due to their age.

- **HEALTH CARE.** An adequate system of health care for the elderly - going beyond Medicare, which is essentially a system of insurance for part of the health costs of the elderly, and Medicaid, which is a system of welfare medicine - must be developed as an integral part of a universal program of comprehensive health care available to all our citizens.

- **MENTAL HEALTH.** The mental health needs of the elderly should receive proportionate attention through a comprehensive health care system.

- **LONG-TERM CARE.** Long-term care should encompass a dual system of care, including both institutional and community settings. Older persons should be sustained to the extent possible in their own environment.

- **LIVING ARRANGEMENT.** The widest choices of living arrangements should be available, designed and located with reference to special needs, at costs that older persons and their families can afford.

- **TRANSPORTATION.** If elderly persons are to benefit from available health, social services and other resources in a community, adequate transportation is necessary.

- **SOCIAL AND OTHER SUPPORTIVE SERVICES.** Social Workers should have an active part in the planning and administration as social services are an integral component of any supportive service system.

- **RURAL ELDERLY.** Programs addressed to the special needs of the elderly in rural areas should be designated to fit their life style.

- **MINORITY ELDERLY.** Minority representation must be increased at all levels of programming as most aging programs were developed for a non-minority population and thus do not adequately address the special needs of the minority elderly.

It is necessary for these areas to be adopted as fundamental values in terms of addressing the issues of the elderly and programs to meet their needs. Pursuing legislation and services resulting in solutions with integrity is the only path to bring about respect to this significant segment of people in our society.

Respectfully Submitted By:

Jim Manning, Chair
Elan Committee

/abr

Dolores Macey
SC NASW
P.O. Box 5008
Columbia, SC 29250

An Approach to Alzheimer's Disease

Alzheimer's disease represents one of the most serious threats to the mental and physical health of the elderly population throughout the country. Epidemologists are now attempting to come up with hard data, but at this time estimates are that 1 - 4 million people are affected with the disease. In South Carolina alone the estimates are from 24 - 30,000 people affected. These figures may be low. One noted South Carolina neurologist recently suggested we may have as many as 60,000 South Carolinians affected. While there are many hypotheses regarding causation of Alzheimer's disease, the only known risk factor is advanced age.

Unfortunately Alzheimer's disease is an "equal opportunity disease". It affects us all - rich, poor, black, white, urban or rural. There is no one in South Carolina who is immune from getting the disease. We are now receiving the news that the experimental drug THA is having disappointing results. Other drug experimentation are equally disappointing. There is at this time no medical treatment available to treat the illness and we are a long way from knowing what causes the disease.

However, we cannot sit back and wait until there is some scientific breakthrough to diagnose or treat this illness. The feeling of "helplessness" that so often accompanies this illness must not be a controlling factor as we approach this devastating disease.

The National Association of Social Workers proposes the following:

1. Continued support for the South Carolina Dementia Registry. It is vital that we have hard data regarding the prevalance of this disease in our state. We need to know what kind of resources are going to be needed in our great stat
2. Development of additional dementia-specific adult day care programs. The South Carolina Department of Mental Health has one such program located at Hall Institute in Columbia. However, Alzheimer's disease does not begin or end in Columbia. The disease also has no geographic preference. It i possible to manage very sick people in a day care environment with trained

staff. This allows caregivers to continue to work.

3. The Day Care Program at Hall Institute- called the A-Team Project - has successfully experimented with having joint activities with local nursery school programs. We purpose that your committeee study the feasibility of developing joint Alzheimer's and children's day care programs.

4. The A-Team in Columbia is now beginning a joint program where adolescents and youth from the Department of Youth Services will be volunteers for the Alzheimer's patients. We recommend that your committee study the possibility of involving other State Agencies such as the Department of Youth Services as we develop programs for the person afflicted with Alzheimer's Disease

Dolores Macey
South Carolina Chapter
National Association of
Social Workers.

Harris - Are there any questions of Ms. Macey?

McLeod - What was the reaction of day care providers?

Macey - I don't know what the reaction to child day care providers is but I can tell you from the experience that we have it has been a wonderful project to see some demented person who hasn't spoken for a while, pick up a child and say something very appropriate and to see the smile on that child's face. This merits some study.

Harris - Any further questions? Dolores, I think you know that I share your concern and frustration over our inability or failure to address what I think is one of the most critical problems. I wanted to ask Fletcher Spigner this morning when he was giving his figures and I failed to do it. About how many of these folks that he sees suffer from Alzheimer's Disease? I just deplore the fact that we haven't done more and I hope we will be able to.

Macey - I hope we will too. You know national figures have to be looked at with some respect and we thought 24,000 to 30,000 people was a large enough number for a very small state like ours but we had a neurologist who said we may have as many as 60,000 people. So we have got to address this issue.

Harris - Thank you again. Pat Harmon, Health Issues Task Force.

Pat Harmon
SC NASW
P.O. Box 5008
Columbia, SC 29250

ORAL TESTIMONY BEFORE THE JOINT LEGISLATIVE COMMITTEE ON AGING

NATIONAL ASSOCIATION OF SOCIAL WORKERS

Chairman Harris, members of the committee and interested others, I am grateful to be here today to speak on behalf of the elderly and their families. They are thankful for the programs and services that are available to them today. However, nobody needs to be reminded of the many who, for whatever reason, are not receiving the services that would enhance their quality of life and give them the type of old age we want for ourselves. Knowing that the millions of dollars it would take to expand current programs and develop others to fill in the gaps will not magically appear perhaps the following need exploration:

1) Develop an incentive for physicians to participate in Medicaid and to accept Medicare assignment. The savings in reduction of crisis hospitalizations and short-term nursing home stays should be significant as well as help develop a prevention consciousness which is known to be cost effective.

2) Develop a housing match program which would link older persons who have space available in their homes with persons of all ages who are in need of housing. There are numerous successful programs in the US which could provide information. Currently unmet needs for housing, transportation, meal preparation, housekeeping, personal care and companionship would all be addressed through such a program.

3) Develop a "volunteer credit bank" whereby persons who volunteered with older persons received "credit" in the volunteer bank against the time when that individual needed volunteer help. What better way to stimulate volunteerism, meet the needs of older persons still living in their homes and ease the demands on

service providers who, even at this point in time, are unable to meet all the service requests received.

The development and implementation of even one of these ideas would have a significant impact on old age as experienced by South Carolinians, whether native-born or transplanted. Your job of deciding legislative priorities is difficult. Thank you for listening and thank you for wanting to make a difference.

Harris - Thank you very much. Any questions of Miss Harmon?

McLeod - I see Mr. Blake on the agenda later and I was under the impression that now we had over 99% participation among physicians with Medicaid and Medicare.

Harmon - I can't speak to figures as others who represent other agencies could. I know from the provider prospective we have a very difficult time with both of those programs in finding health care for our clients especially Medicaid. Just this week we were trying to get a listing of the physicians who were Medicaid participants and we may have another lead on that. Everywhere we have turned we have not been able to get that information.

McLeod - I'll ask Dr. Blake because I was under the impression about close to 100% were now participating.

Harmon - Possible with Medicare but the word we have gotten and we've found from our clients is that many physicians who were Medicare participants are now choosing not to accept assignment for paper and reimbursement reasons. I have heard that physicians who did accept Medicaid which were a small minority of the physicians are no longer doing so because of paperwork. This is what we are hearing from physicians and clients but that's not hard core facts.

Lourie - What is the Health Issues Task Force?

Harmon - I'd like to refer to JoAnne St. Clair.

Clair - I'm Executive Director of SC Chapter of National Association of Social Workers. The Health issues Task Force is one of the many committees that the National Association and S.C. has. This committee is looking at various health issues and problems in S.C.

Lourie - Do you overlap?

Clair - This is a committee of S.C. National Association of Social Workers for our members. It is a private organization.

Harris - Thank you very much. Moving on the next presentator is Margaret L. Baptiste, President of SC Retired Federal Employees.

Margaret L. Baptiste, President
NAFRE
621 Pelzer Drive
Mt. Pleasant, SC 29464

SOUTH CAROLINA FEDERATION OF CHAPTERS
National Association of Retired Federal Employees

Members of the Committee, Ladies and Gentlemen. My name is Margaret Baptiste and I am currently President of the South Carolina Federation of Chapters of the National Association of Retired Federal Employees, an organisation which was formed in 1921 and is solely devoted to protecting the individual and family interests of civilians who have retired or will retire from Federal Service.

The National Association of Retired Federal Employees currently has over half a million members and has 3,681 chapter members in the State of South Carolina. There are approximately 27,000 retired federal civilian annuitants and survivor annuitants in our State.

On March 28, 1989, the United States Supreme Court ruled that States may not discriminate against federal retired workers by taxing their annuities if they exempt the pensions of state and local employees from such taxation. This unfair tax situation has applied in this State since 1945 and under the laws of the State of South Carolina a refund can only be sought for the preceding three years. I doubt that there are many living retirees or annuitants who have been receiving a pension since 1945 but there are many retirees who have been retired for over 20 years and can only claim a refund for the past three years.

Federal and Military retirees pay their full share of all other taxes. In fact those over 65 pay taxes that other people do not. Many federal retirees are covered under Medicare and they also contribute to Health Insurance under the Federal Employees Health Benefit Plan and now face a surcharge placed on them and them alone under the provisions of the new Catastrophic Health Care plan. A plan, which unless it is repealed or amended will mean that 40% of all retirees will be covering the costs of the other 60% - another gross inequity. This plan will also give them double coverage in many areas, which they will have to pay for but do not need.

Retirees are now recognised in many States as a growth industry. When they move into a Sate, they purchase homes, bring their life savings with them to invest in local banks and other financial institutions and are a source of profit to the State to which they have moved. We ask that the Legislature recognise Retirees as such an industry and would ask that the State Legislature treat us in a manner mandated by the Supreme Court ruling in Davis v Michigan. All we ask for is fair and equal treatment.

Margaret L. Baptiste
President, SC Federation of Chapters
National Association of Retired Federal Employees.

September 20, 1989

Harris - Thank you, Miss Baptiste. Any questions?

Blackwell - Miss Baptiste, maybe I should wait and ask this later. They are now treating you fairly and equally as to the future years because they have now begun to attach the State Retirees. Right?

Baptiste - We have an argument. If you have 4 apples and I only have 2 apples because you are already getting a raise, you are given another apple and we are not, then they take your apple away. You still have 4 and we only have 2. So we maintain that we are still not getting treated fairly.

Blackwell - The question that I'm coming to is: Let's assume we drag our heels about refunding these 4 years of taxes. I have to tell you frankly I don't see that money being available in the coming years certainly not for all 4 years at one time. What would be the attitude of your association toward tax credits rather than refunds.

Baptiste - I could not speak for the entire membership. But let me put it this way, I believe we would be in favor of that. Very definitely!

Harris - Thank you very much, Miss Baptiste. Our next presentator is Walter Reed, Legislative Chair.

Walter Reed, Legislative Chairman
NAFRE
104 Reed Hall Rd.
Summerville, SC 29483

Walter G. Reed, Legislative Chairman, NARFE S. C. Federation
104 Reed Hall Rd. Summerville, S. C. 29483

Mr. Chairman; and members of the committee on aging.
Ladies and Gentlemen;

My subject concerns the taxation of Federal Retiree's annuity and the return of taxes collected illegally. What should have been a very simple matter to correct turned into a farce by what I understand was the fenagling and manipulation of Senators Waddell and Lensey, which most of their colleagues approved.

When the supreme court ruled in the case of Davis verses Michigan, it did not give South Carolina any special privilege, but found S. C. guilty along with some twenty other states. The legislature of S. C. seems to compound the matter by denying the federal retirees that which is legally and rightfully his. I believe the state knew it was wrong to collect taxes on federal retiree's annuity and not on the annuity of state retiree's, thus providing the state retirees a special privilege not provided other retirees. The legislature further complicates the matter by allowing the state retiree compensation to offset the taxing of his annuity above 3,000 dollars. A 3,000 dollar exemption was granted the federal retiree a few years ago, while the state retiree's annuity was totally exempt from state taxes.

It appears now that the only thing left for the federal retiree to do is to take the state to court. Since the court has already ruled in favor of the retiree it is not likely that the state can win. The state could end up paying more than the refund owed the retiree, such as court cost, lawyer fees and interest on the refund. If that is what the state wants I am sure the federal retirees can oblige. There are at least two suits filed now and there can be may others.

What I am asking of the committee is, use your influence to persuade the state to return the illegally collected taxes. It will be less costly to everyone concerned to do this with legislation rather than a law suit. Some of the retirees are up in years and some are ill and if a court action is required to get the refund due them, they may not be here to receive it.

I thank you for hearing me and for your consideration in this matter.

Walter G. Reed

Harris - Thank you very much. Any questions of Mr. Reed?

McLeod - I'd like to make a statement. I guess as a member of the General Assembly to admit that sometimes maybe we don't know what we are doing, we did make some errors in my judgment about that. I know Senator Waddell also wrote a lot of people and I did also about filing for the refunds and so forth. The language did not address the issue as myself and Senator Waddell. (I've talked with him.) There is going to be some prefile legislation about it to try to fix the problem. Now, I don't envision that's it is going to go back more but it remains to be seen what this crowd will do. It probably will not go back any further than 3 years.

Blackwell - I'd like to ask you for the record, sir. Does your organization feel that the state General Assembly does not have the right to change the state retired employees benefit? If it choses to.

Reed - No sir.

Blackwell - I thought you were being critical of us for giving them more money.

Reed - The criticism is that you offset the tax that the state employee has to pay.

Blackwell - Yes sir. Well are you saying that we shouldn't have done that?

Reed - Why should you offset his tax when you didn't offset ours?

Blackwell - I won't argue the point with you. I want to know whether you are saying that what we did for the state employees was illegal.

Reed - I don't think it was partly right.

Blackwell - You don't think it was right.

Reed - No I don't think you should treat one entity any different from another. We are all citizens of S.C. and we should enjoy the same treatment.

Blackwell - Thank you, sir.

Harris - Let me ask a question. Of course, the Michigan case only dealt with public employees. What is your feeling about the AARP? Do they come in and say treat us exactly the same way. Even though we were in the private sector. None of our earned dollars came out of the taxpayer's pocket. What is your feeling on this?

Reed - Unfortunately the AARP members most of them are already covered by your procedures. Most of their income is tax-free.

Blackwell - What's your feeling about Social Security benefits?

Reed - That's tax-free. We are the only people whose annuity is totally taxed by the state and federal government.

Harris - You mean the retirees in private sector don't pay taxes on retirement?

Reed - On social security, no sir.

Harris - No, I'm talking about the retirement benefits.

Reed - A few of them pay a little taxes but not like we do. Our total annuity is taxed.

Blackwell - After the first $3000.

Reed - We only got that 3 years ago and I was one of the fellows to help get it. So I know all about that $3000 bucks before that it was $1200 and before that it was nothing. We haven't been in this exempt business very long.

Blackwell - I want to say for the record, sir. You understand I'm a retired federal employee and I got $6100 riding on this thing myself.

Reed - You have.

Blackwell - Yes sir.

Reed - Bless your heart.

Harris - $6100 will help Mr. Blackwell do most anything.

Reed - One of our good friends from Charleston is going to prefile a bill to give tax credits to pay back this money. What do you think that is going to do to alot of retirees that's up in age? Do you think they will collect that credit. I don't think so. I think the undertaker is going to say Grace a long time before they ever collect. Thank you, gentlemen.

Harris - Thank you very much. The next presentator is Colonel Angelo Perri, Vice-President, of SC Council of Chapters of the Retired Officers Association.

Col. Angelo Perri, Vice-President
S.C. Council of Chapters of the
Retired Officers Assn.
P.O. Box 2241
Columbia, SC 29202

SOUTH CAROLINA COUNCIL OF CHAPTERS
THE RETIRED OFFICERS ASSOCIATION

STATE INCOME TAX AND FEDERAL RETIREES

PRESENTATION TO THE JOINT LEGISLATIVE COMMITTEE ON AGING
Public Hearing September 20, 1989 - Room 101
Blatt Building
Columbia, South Carolina

Presenter: Colonel ANGELO PERRI (USA Retired) Vice President, S.C. Council of Chapters, The Retired Officers Association

Ladies and Gentlemen:

As you are well aware, much has transpired since we met one year ago. First, bills were introduced into both the S.C. House and Senate that sought to raise the state income tax exclusion for federal retirees and all citizens over age 65 from $3,000 to $6,000. A public hearing was held in March 1989 and it appeared that favorable action would result. This was followed closely by the U.S. Supreme Court Decision of DAVIS vs. THE STATE OF MICHIGAN which completely turned the situation around. To better understand where we are TODAY, it will help to review what has gone before. Please allow me to recapitulate.

Federal Income Tax was started shortly before World War I. S.C. enacted state income tax in 1929. In 1939, the U.S. Congress passed the Public Salary Act of 1939 that permitted states for the first time to levy state income tax on federal employees as long as it was done on a NON-DISCRIMINATORY basis. In 1945, S.C. elected to stop taxing state and local government retirees, but continued

to tax federal retirees until 1969, when they were granted a $1,200 exclusion, which was raised to $2,100 in 1985 and to $3,000 in 1986.

The U.S. Supreme Court decision announced on March 28, 1989, held that such income tax schemes violated the principles of intergovernmental tax immunity by favoring state/local government retirees over federal retirees, and there was a MANDATE for equal treatment. In theory, federal/military retirees have been discriminated against since 1945, the year S.C. stopped taxing their state retirees.

The Legislature took action to solve this MANDATE by voting to tax state retirees and gave them the same $3,000 exclusion, as well as a seven (7) percent salary adjustment, which in essence equals closely the amount of state income tax each state retiree will have to pay in the future. It took no action on federal retirees.

In April, 1989, a law suit was filed by federal retirees in Surfside Beach, S.C. seeking to force the state to refund as overpayments state income tax paid for the years 1985 through 1988. An additional law suit was filed August 18, 1989, by our group, The Retired Officers Association, seeking refunds for the years 1945 through 1988. An order issued by Judge Kay Hearn of the Horry County Circuit Court on August 30, 1989 has ruled that a class action law suit is lawful on tax matters, a position that the state had not agreed to. If the Surfside Beach law suit is successful, S.C. will have to pay back some $150 million to 61,000 federal

retirees for the years 1985 through 1988. If our law suit is successful, the figure could reach $500 million for the years 1945 through 1988.

We regret that court action has become necessary. Most federal retirees would have been very pleased to receive refunds for the years, 1985 through 1989, as provided by the Statue of Limitations, and perhaps an increase of the exemption from $3,000 to $6,000 or higher. Refunds could have been spread over several years to minimize the impact on state revenues.

With that as background, let us discuss why there should be any state income exclusion at all. QUITE FRANKLY, income tax exclusions are economic initiatives. They are designed to attract to a state individuals who will bring their retirement income, investments, bank deposits, skills, time, and talents to that state. Many begin second careers, small businesses, and then pay state income tax on their pensions, second incomes, investments, etc. S.C. currently has 61,000 federal retirees which have an annual payroll of some $700 million dollars, and their presence creates some 70,000 jobs. Recognizing this economic impact, most states do everything reasonable to attract retirees of the higher income and educational brackets. The current $3,000 S.C. exclusion is the lowest in the SOUTHEAST and has a negative impact. From 1983 through 1988, over 15,000 military personnel retired to FLORIDA and only 3,700 came to South Carolina. The $3,000 exclusion will tend to attract only those retirees with the LOWEST incomes; those who pay little or NO state income tax. Those individuals could well

become, in later life, an additional burden on S.C.'s social and medical systems. The retirees with the larger pensions and the higher skills and education will tend to retire to those states that have the higher exclusions, or no state income tax at all. To have kept up with inflation, the original $1,200 S.C. state income tax exclusion of 1969 should have been raised to $7,200; yet it stands at only $3,000.

We ask that this Committee, after careful deliberation, take a leadership role in the Legislature in two fronts:

1. Urge that the Legislature appropriate funds to make refunds to federal retirees for the years 1985 through 1988. Such refunds to be phased in, or granted as a "tax credit" so as to minimize the impact on state revenues. The 1985 refunds could be made in 1990, the 1986 refunds in 1991, etc.

2. Urge the passing of the bills, that seek to raise the state income tax exclusion from $3,000 to a higher figure. We recognize that such exclusions now apply to state retirees, as well as to citizens over age 65. This action can also be phased in over a 5-year period. A higher exclusion will serve to attract the higher quality retirees, with the higher incomes and skills, and will help to offset the refunds, if we are able to convince enough of those retirees to relocated to South Carolina.

Those of us who are now here will of course tend to stay; for a variety of reasons, we will not move away. Regretfully, we wish

we could portray a more favorable picture for the future - to clearly illustrate the negative impact of a low state income tax exclusion, in smaller numbers we can understand:

From 1983 through 1988
Columbia, South Carolina

Home of Fort Jackson, The University of South Carolina, an all-American city - one of the so-called most liveable cities in America gained only 1,065 military retirees of 106,000 that retired; Columbia had 11,411 military retirees living here in 1983 and only has some 12,475 living here in 1989.

We thank you for time, attention and consideration.

RETIREES, ALABAMA WANTS YOU

In Alabama, "golden years" has taken on new meaning. Economic development officials hope to make luring retirees to the state a new growth industry. The "retiree pie is big and getting bigger," says Jacksonville State University's Mark Fagan, an associate professor of sociology who was appointed by Republican Governor Guy Hunt as a consultant to the Alabama Program to Attract Retirees. Fagan, working with the university's Center for Economic Development and Business Research, has come out with a new report on retiree-based economic development. The report covers what retirees are looking for in a retirement site, how to attract them and what they're worth to state and local economies.

Mark Fagan heads Alabama's Program to Attract Retirees.

Currently there are more than 60 million Americans over the age of 50; the number will grow to more than 100 million by the year 2020. And Alabama has what retirees are after, says Fagan: low crime, nice scenery, a mild climate, and moderate taxes and cost of living.

Fagan is currently traveling around the state to help launch "retirement development advisory boards," made up of local officials and business leaders, to develop housing and health care facilities and such amenities as golf courses and parks.

The incentives to pursue retirees are there, Fagan's analysis shows. When retirees move, they bring with them an average net worth of $250,000, the cash portion of which is deposited in local banks. Further, they spend between 70 and 90 percent of their average $25,000 annual income locally.

Trying to attract retirees is not a bad economic development strategy, says Richard E. Starr, vice president of Economic Research Associates, an independent economic consulting firm based in Los Angeles. "Retirees bring bank deposits, income and free time. They demand few services and can, in fact, become a valuable talent pool if you figure out how to tap it." Few states, if any, have active recruitment programs, Starr says.

The down side of the strategy, says Starr, A state has to have the amenities retirees are after, or be willing to develop them. Also, retirees tend to be unwilling to vote for bond issues for civic improvements, such as schools.

Down side or not, says Fagan, the economic benefits can't be ignored — right down to local car dealers. "[Retirees] buy big American cars, like Fords, with V-8 engines," he points out. "In fact, they buy 48 percent of all luxury cars sold in America."

—Jonathan Walters

Yuko Clemmer/Picture Group photograph

DENVER DRIVER'S A TRASH-TRUCKING CHAMP

He's the trash truckers' No. 1 buckaroo: Albee Sandoval, who maneuvered his front-loader trash truck through five obstacle courses to win the International Governmental Refuse Collection and Disposal Association's fourth annual rodeo, held in Baltimore. Sandoval drives for Laidlaw Waste Systems, which collects Denver's municipal trash. He bested 38 colleagues from both municipal and private trash collection outfits as he wheeled his 34-foot-long truck through parallel parking, backing, sharp-turn, swerve and straight-line courses, racking up 380 points out of a possible 450.

"I think a lot of guys were nervous," says the 34-year-old Sandoval, who has been in the saddle since the age of 16, when he went to work for his father's Denver-based trash collec-

GOLDEN PROSPECTS

Recruiting retirees can help turn a bust into a boomtown

While homeowners may curse leaden property values, communities from Maine to Alabama are discovering that their bargain basements can prove to be golden lures—for senior citizens, that is.

In bucolic Hot Springs, Ark., the housing market was flagging, along with tourism, until Rand McNally ranked the town third on its 1987 list of best places to retire. Now, the resort has become the first in the country to boast a full-time recruiter of the elderly: thanks to the efforts of native Jane Ann Crone, 50, and her team of volunteers, the resort has attracted hundreds of elderly visitors; 30 couples, drawn to the area's low-cost homes, have settled there permanently.

Silver dollars. Other regions are rushing to follow suit. Maine legislators are considering new rules to woo retirement-center developers. In rural McCormick County, S.C., the state government is paying for the construction of roads and water lines in a privately developed residential complex, and recouping the money through a special property tax. Alabama officials are peddling their state's inexpensive land and fresh air in the hope of encouraging older tourists to return and set up house. "Most retirees visit a place three or four times before they decide to move there, which is why we're trying to tie in tourism," explains Mark Fagan, a sociology professor at Alabama's Jacksonville State University who is organizing a state-sponsored reunion this year of former residents.

Far from posing a problem for resource-strapped townships, seniors are seen as an attractive alternative to smokestack industries for boosting local economies. As a group, the nation's 60 million older citizens control three fourths of America's financial assets and boast average family incomes of more than $25,000. Moreover, once retired couples relocate, they tend to stay put, bringing more money into communities without putting a strain on school or law-enforcement services. "Even a modest influx of retirees can stabilize a local economy and contribute to the critical mass of activity needed for retail outlets, restaurants, banks and civic organizations," notes Richard Gardner, an Idaho policy analyst who is trying to persuade fellow state officials to consider seniors as tools for growth. Unlike young working families, older Americans seem less likely to reject the idea of moving to areas that cannot offer high-quality schools or a healthy job market.

Some government planners remain wary of coaxing large numbers of the elderly to pack up and move. They cite the need for more nursing-care facilities and special transportation systems to accommodate the frailer newcomers, and note that active oldsters often want improved sports facilities.

So far, the pluses have far outweighed the potential costs of an increased senior population. Federal medicare covers much of the health-care cost, for instance. And the seniors' contribution to the local tax base more than makes up for what their medicaid payments might cost the state. "We found that Southern states do, indeed, view the elderly as a great economic asset," says Brandeis University economist William Crown, a specialist in issues affecting the aged.

Certainly Hot Springs can attest to the merits of filling empty nests with retirees. Effervescent Jane Ann Crone, the doyenne of senior-recruiters, touts the low cost of living near the scenic Ouachita Mountains in brochures and ads in newspapers as well as magazines like *Southern Living*. After one year of operation, she reports receiving more than 4,000 inquiries about the city and its dozens of new residents. Among the settlers are C. J. Geraci, a retired 80-year-old physician from Belzona, Miss., and his spouse. A few visits to the mineral baths and several parties convinced the couple to move into a two-bedroom rental cottage that costs $1,100 a month, including dinner every weeknight. "We feel happier than we have since high school," says wife Sally. ■

Senior ambassadors. *Jane Ann Crone's recruiters woo newcomers to Hot Springs*

by Sandra Gregg

U.S.NEWS & WORLD REPORT, March 6, 1989

Harris - Thank you, Colonel. Any questions of Colonel Perri?

Lourie - The article also refers to McCormick, S.C.

Perri - Yes. Since you bring up McCormick, S.C. The state has invested some $17 million there to help balance Savannah Lakes which will build 5000 homes each selling probably around $100,000 a piece and will create 4000 jobs in McCormick county. Where are you going to get the retirees to buy those homes? If you don't do something about this tax exclusion.

Lourie - It's very legitimate.

Perri - It is sir because we are going to attract this retiree industry. We spent so much on tourism for the very short week or two that they are here but we do very little to get them to come and stay with us. So we can get their money. I can't put it any other way.

Harris - Thank you again, Colonel. The presentator is Mr. Eric Bouchard, Vice-President, of Providence Hospital.

Eric Bouchard, Vice-President
Providence Hospital
2435 Forest Dr.
Columbia, SC 29204

SENSITIZING THE SERVICE ENVIRONMENT TO THE OLDER CONSUMER

Eric Bouchard
Vice President
Providence Heart Institute
Columbia, SC

Health care's number one consumer is the older American. The growing evidence is reflected in the number of elders who seek health care services at every provider level. Greying America is the visible evidence that aging is the future of healthcare and health care executives agree that aging is the market of the future. How can we sensitize the environment to cater to older health care consumers? Health care providers need strategies to raise the level of awareness of hospital staff about the needs and expectations of older patients. In addition, the organization may need education on how to serve the needs of seniors in a more effective manner.

America's senior citizens are one of the most vulnerable populations in need of health care services and despite a climate of declining Medicare reimbursement dollars, the Medicare market share of most providers continues to expand. Good consumer relations skills are necessary to attract the high potential market of elderly consumers. Health concerns are a top priority on the minds of older people and organizations that recognize the potential and the uniqueness of this market will win the loyalty of these

important consumers by simply creating an institutional focus on service.

This business of providing health care services is dependent upon an increasing trend of consumers playing prominent roles in selecting their own health care provider. This tough new challenge is being met with strategies for improving patient relations and enhancing the Healthcare environment. These, along with educating the community about specialized healthcare services, are topics being examined in virtually all facilities that are seeking a competitive edge.

This high-touch approach to humanizing a high tech environment is a consumer oriented philosophy that sets in place a process that promotes excellent relations and consumer satisfaction. If you inquire of any buyer who his favorite employee is, the responses are mostly the same: everyone likes to be around people who are responsive, know how to listen, seem to care, have a sense of humor, show respect, and display warmth.

How to create a more consumer-oriented work force that will help health care organizations compete successfully in a competitive market is a current principal focus of human resources management. Employees are a visible and integral

component of marketing strategy. With all this attention on growing competitive pressures, it is not surprising that top management is asking for quality recruits and placing more emphasis on training people who show aptitude for the desired behaviors of customer relations.

Orientation to customer relations expectations should carry an explicit message that an attentive, cohesive, productive and motivated staff with a clear understanding of what is required to satisfy the public is the desired end result. All employees, regardless of their role in the organization, should understand that they have the responsibility for determining the future. This customer relations aspect of marketing is an important strategy for keeping the business you have and encouraging more. This marketing strategy looks at the consumer, both as someone in need of healthcare and as someone with real purchasing power.

The organization's expectations for customer satisfaction must be clear from the outset. The customer relations training should translate marketing concerns into practical demonstrations of how costumer relations skills build staff satisfaction and promote wellness too. Brief courteous encounters have a significant effect on setting the tone for a consumer's experiences in the health care environment.

Total involvement of all staff members in courtesy awareness assures a general enabling atmosphere.

Healthcare providers across the nation are becoming increasingly aware of the strategic importance of the elder market. It is well past time for organizations to assess their ability to deliver high quality programs to the significant market of older consumers. Successful providers are already innovatively responding to this continuum of care with increased awareness of the older person's desire for an accessible secure health care environment delivered with a spirit of service.

pd

C:/EAB/8308-3.

Conmy - May I read into the record a letter from Ms. Oehler?

Harris - Thank you, Miss Conmy. Are there any questions?

McLeod - I had some experience about some requirements about child care regulations. I thought they were a little outrageous. I'm not familiar with what the regulations are with adult care facilities. That may be something we do need to look at. They did have some over burdensome regulations on child care some years back.

Conmy - The biggest problem in being able to comply is not providing enough room but providing the specialized vans to transport these people around. We have a radius of 8 to 16 miles. The elderly are well cared for and planned for if they meet these very strict guidelines of being skilled nursing. They need this temporary help and majority of them just can't afford it.

McLeod - One of the requirements is to have hoods that cover the cooking facility like a hotel has. The thing costs about $75,000.

Harris - Thank you very much, Miss Conmy and Senator McLeod. Next presentator is Jerome Noble, Director of Division of Public Transportation with SC Department of Highways and Transportation.

Te Anne Oehler, MSW, ACSW, LISW
410 32nd Ave., N
Myrtle Beach, SC 29578

To: Patrick B. Harris, Chairman
Joint Legislative Committee on Aging

From: Te Anne Oehler, ACSW, LISW

Date: Sept. 18, 1989

I speak today as a lifelong citizen of Horry County since 1954 and as a professional social worker providing geriatric care management for retirees in frail health who want to remain in their own homes. There have been many changes in Horry County since my grandparents helped to pioneer this area in the late 1920's in the composition of the population and in changing values and behavior in the care of the frail elderly.

Within the last five to ten years, the percentage of adults over 55 has grown as have the number of retirees, both residents and those moving to this area for retirement. Approximately eleven (11%) percent of our population is over 55. The most rapidly growing group are those over 75. The over 75 are also the most frail with the least access to medical care, health and support services to enable them to remain in their own homes. By the year 2000, the State Data Center projects our retirement population will compose approximately 13% of our total population in Horry County. This does not even address that area of the Grand Strand called the Waccamaw Neck in Georgetown County.

My concern is not only for the citizens of Horry County but also South Carolina. I cannot ask the Legislative Committee on Aging to change the values, attitudes and behavior of the citizens of our great state, but I will ask that you take a leadership role in focusing on identifying the problems of availability, accessibility and funding programs and services for retirees.

Adapting to the aging process is a significant social issue. It has existed since Biblical times. Now we face a growing aging population with longer life spans but more chronically ill and functionally disabled with more transient families and two career couples leaving fewer wives, mothers, sisters, daughter and daughters-in-law to provide the long term caregiving.

I am a licensed and certified clinical social worker with a background in medical care and geriatric training from the University of North Carolina at Chapel Hill and the Center for Aging at Duke. I have been in practice for fifteen years. Geriatric care management provides a comprehensive evaluation, coordination of services and monitored follow-up to enable retirees with health problems to remain in their homes. Services include assessment of mental and physical functioning , identifying and monitoring local geriatric services and resources, conseling and future planning, liaison with family, coordination of medical and other services, home, hospital and nursing home visits, 24 hour emergency message coverage and comprehensive care management.

We, as state leaders cannot do less than heroically meet the challenges of the needs of the retirees in South Carolina to live with our conscience and prepare for the twenty first century.

Te Anne Oehler, MSW, ACSW, LISW
410 32nd Ave. N.
Myrtle Beach, SC 29578

Eleanor Conmy, R.N., Director
E&E Personal Care Agency, Inc.
249 Holly Circle
Myrtle Beach, SC 29577

To: [redacted], Chairman
Joint Legislative Committee on Aging

Fr: Eleanor C. Conmy,RN/Director
E. & E. Personal Care Agency,Inc.

Aging is a process.....as I speak- I am aging, all of us are aging. For 32 years I have been actively involved in the practice of nursing --Cradle to Grave concept, --in the acute care hospital, nursing home, home health, research..disaster nursing. The last four years I have been helping to care for people and families who need help to stay safely in their homes. via E & E Personal Care Agency, Inc. This care is of a NON SKILLED nature (for those who do ;no meet the crieteria for Home health care guide lines. There are literally thousands of us who will or are already falling thru the cracks. Non skilled care, sometimes referred to as custodial care can be provided by certified personal care aides, or housekeeper aides. They can provide the essential things like assisting with bathing, cooking, laundry, shopping, transport to necessary appointments etc. or compatible companion...the need for which we younger ones are just begining to understand. . These are out of pocket expenses , and should these services be required on a 24/hr basis for a prolonged period financial status can be diminished to poverty level very quickly .....It is referred to spending down until medic-aide can pick up,,,, or you may be elligible for community long term care. To add to this already burgeoning problem hospitals are required to discharge sooner---DRG's to homes often to what results ;in unsafe living conditions, the existing nursing home bed shortage, the increasing numbers of patients discharged from re-hab units the increasing numbers of Alzheimer's etc. care must be provided by someone, Consider the hours lost to the work place as family members have to stay home to care, the quality of life lost or degraded.the outlook for very great numbers of us is bleak at least.Therefore we request provision for AFFORDABLE coverage to help to defray the cost for care as "we" [redacted]
It strikes me as strange that states, banks ,lein holders require insurances on cars, homes etc., to protect their investments----but there in no requirement to protect our investment-- human beings, when we are now most vunerable. There is only one insurance available now thru AARP which is begining to address the needs for non-skilled home care, it is very expensive and excluded those over the 79 yr mark. As per prior testimony there many of us already in that situation.

Another compounding problem is the lack of adult day care centers According to existing state guide lines and requirements the cost to initiate or comply is prohibitive.
We would suggest modification similar to child day care , provide SAFE care in standard -type family homes .... a maximum of 10 - 12 clients, located in their own neighborhood--- less trauma of relocation (as transporting long distances in vans) less stress to all--- clients, care givers..greatly reduced risk of abuse (client to client, client to care giver & visa-versa)

Due to the high cost of start-up we would request some sort of grant, or low cost finincial pkg be made available.

Encolsures: Proj. for Elderly , Wellsprings, Erie,Pa.
Program initiated via private sector.

Respectfully submitted:

ELEANOR C. CONMY,RN /Dir.
E & E Personal Care Agency, Inc.
249 Holly Ci.
Myrtle Beach, SC 29577

Jerome Mobie
Division of Public Transportation
SC Dept. of Highways & Transportatic
P.O. Box 191
Columbia, SC 29202

SOUTH CAROLINA FIVE-YEAR PUBLIC TRANSPORTATION DEVELOPMENT PLAN (TDP)

FACT SHEET

Report Title: SOUTH CAROLINA FIVE-YEAR PUBLIC TRANSPORTATION DEVELOPMENT PLAN, 1989 - 1993

Prepared by: Wilbur Smith Associates, under contract to the South Carolina Department of Highways and Public Transportation (SCDHPT); a 15 member Statewide Advisory Committee (State agencies, commissions, entities and the private sector); and ten Regional Advisory Committees comprising 161 members (RTA's, human services transportation providers, local government, the private sector, and others).

Scope: Prepared in response to a Legislative request. The Plan is a comprehensive evaluation of all forms of public transportation in S.C. -- urban and rural bus systems, vans, human services transportation, intercity bus, taxis, ridesharing and other forms of transit.

Findings:

a. There are 315 individual, somewhat autonomous, public transportation providers in S.C. However, residents of one-half of the State's counties still remain without open-to-the-public transit.

b. Public transportation supports South Carolina's economy by transporting citizens for employment, medical, shopping, educational, human services and other essential purposes.

c. Greater coordination is needed among the human services agency providers of transportation, and between those agencies and other transit providers.

d. The public transportation systems in S.C. are providing general public transportation as efficiently, or more efficiently, than are comparable systems nationally.

e. Nationally, public transportation systems rely on public financial assistance. This is also true in S.C. and such assistance continues to be needed to maintain the viability of the S.C. systems.

f. Given that federal funding is declining, the State's public transportation operators will be faced with funding shortfalls which need to be made up from State and local sources. An estimated deficit of $3.3 million is anticipated to support public transportation, annually.

g. Currently, there is no dedicated source of funding for public transportation.

Recommendations:

1. A reliable, dedicated State source of funding is essential, in an amount three times as large as the funds now available for public transportation service provision.

2. Coordination among public transportation providers should be Legislatively required (eligibility for State assistance).

3. Performance standards should be utilized by all State funding agencies to better monitor public transportation effectiveness and efficiency.

4. RTA's development should be encouraged, including elimination of the "Referendum Requirement".

5. A public transportation coordinating mechanism is needed at regional levels in S.C., perhaps one in each of ten regions.

6. A separate Statewide study should be undertaken to assess the elderly and other specialized transportation needs in the State given the anticipated growth of this population segment in S.C.

Commission Action: On April 20, 1989, the South Carolina Highways and Public Transportation Commission adopted the Statewide TDP, agreed to present and go on record requesting the General Assembly to accept the Five-Year Public Transportation Development Plan as a fulfillment of the 1984 legislative mandate. Further, the Commission agreed to request from the General Assembly, an increase of $3.3 million in State General Funds (above and beyond the present appropriation level) to be dedicated annually to support the Department's statewide public transportation program and to implement the Plan's recommendations starting FY '89-'90. The Commission presented the plan to the General Assembly on May 18, 1989.

Harris - **Thank you very much, Mr. Noble. Any questions?**

Lourie - **This is my issue.**

Harris - **All of this program kind of belongs to Senator Lourie. All those that have enjoyed the benefits need to thank him because he fought long and hard. I know he had a lot of frustration along the way.**

Lourie - **I just wanted to observe that the money is being used for Public Transportation and buying vans for the various councils on Aging, Handicap, and so forth. The one-fourth of one cent that we have been able to use in the last 2 years has to be renewed each year. Obviously it's always a tedious question whether we can get it back in the Appropriation bill. Senator McConnell and I will be introducing legislation to earmark the**

interest from the Highway Department fund. That interest comes to approximately $20 million a year that is the money that comes in from the gasoline tax, titles, driver's licenses, and everything. While that money is setting in the fund before it is being used, it brings in approximately $20 million a year. Our legislation will earmark that money to be used for the Highway Department. One fourth of that money is to be earmarked permanently for the Transportation and I would hope the Committee could see fit in these deliberations to endorse that proposal because a significant number will be needed this year to pass that law. In connection therewith I might note that N.C. has just passed one tremendous package of new revenues for their Transportation programs and highways and so forth. Our highway department will have a definite need for increased revenues in the forthcoming period. We hope this interest money will help alleviate the situation. N.C. is going to tax 20.5¢ per gallon of gasoline plus they have substantially increased sales tax of automobiles. A matter of interest is that tourism is one of our greatest sources of revenue. They are trying to become very competitive with our tourism and developing the N.C. coast to be competitive with the Grand Strand. We will have to see how that develops.

Harris - Thank you, Senator Lourie. Any other questions?

McLeod - I'm well aware of Senator Lourie struggling year after year about this thing. Do you think the time has come to have a separate Transportation Department? I mean the Highway Department is always hurting for money and Transportation just gets lost in the shuffle over there. It has been going on so long. Issie, I don't think it is ever going to get right unless we address it as a separate issue.

Lourie - Well, I think there's alot of thinking toward that end, Senator. Create the Public Transportation division as a separate entity from the Highway Department.

Noble - In response to Senator McLeod's question, the Department receives its powers from the General Assembly. The General Assembly is responsible for creating the various divisions within the department. I think that would have to be a deliberation of the General Assembly.

Harris - Thank you, Mr. Noble. The next presentator is Mary Gail Douglas, President of SC Association of Council on Aging Directors.

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING
TESTIMONY

SEPTEMBER 20, 1989

MARY GAIL DOUGLAS, PRESIDEN
S. C. ASSOCIATION OF COUNCI
ON AGING DIRECTORS
210 E. WASHINGTON STREET
WINNSBORO, S. C. 29180

MR. CHAIRMAN AND MEMBERS OF THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING:

MY NAME IS MARY GAIL DOUGLAS AND I AM HERE TODAY REPRESENTING THE S.C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS. OUR ASSOCIATION HAS RELIED ON YOU AS A GROUP IN THE PAST TO ASSIST US IN OUR EFFORTS TO BETTER SERVE THE ELDERLY IN OUR STATE. WE CONTINUE TO SOLICIT YOUR HELP AND SUPPORT FOR THE TASKS THAT ARE BEFORE US. THE ATTENTION THAT IS GIVEN TO THE ELDERLY IN THIS STATE IS MINIMAL AS FAR AS MANY OF THE OTHER LEGISLATORS GO. WE BELIEVE THAT IT IS TIME TO ASK OUR LEGISLATIVE BODY WHERE THE ISSUES OF THE ELDERLY FIT INTO ITS SCALE OR PRIORITIES. THE FACT THAT S. C. HAS BEEN NAMED AS THE THIRD FASTEST GROWING RETIREMENT STATE FORCES US AS ADVOCATES AND LAWMAKERS TO UP-GRADE THE ISSUES OF THE ELDERLY. ATTACHED IS A STUDY THAT OUR ASSOCIATION COMPLETED DURING MARCH OF THIS YEAR. IT IS A COMPILATION OF SERVICES AND AMOUNTS OF FUNDING AT THE SERVICE DELIVERY LEVEL. THERE ARE 38 COUNTIES WHO RESPONDED TO THIS SURVEY AND WHAT WE FOUND SO ASTOUNDING IS THAT THE STATE'S PORTION OF THE DOLLARS SHOWN REPRESENT THE REQUIRED AMOUNT THAT IS NEEDED TO DRAW DOWN FEDERAL DOLLARS. AS YOU CAN SEE, OF A TOTAL REVENUE OF MORE THAN $13 MILLION AT THE LOCAL LEVEL, ONLY 5.8% OF THIS MONEY WAS REPORTED AS DOLLARS FROM STATE SOURCES. WE KNOW THAT THE STATE OF SOUTH CAROLINA CAN DO BETTER THAN THIS FOR ITS ELDERLY.

WE CONTINUE TO BE CONCERNED THAT THE ELDERLY ARE OFTEN TIMES FOUND AT THE BOTTOM OF THE PILE; IF AT TIMES THEY ARE FOUND AT ALL. AN ARTICLE IN THE STATE NEWSPAPER ON SEPTEMBER 13, 1989 LISTED THE DIRECTOR OF THE NURSING HOME LICENSURE BOARD AGAIN AT THE BOTTOM OF THE LIST. NURSING HOME LICENSURE DESERVES A HIGHER DEGREE OF STATUS THAN THIS. SHOULD IT NOT BE RIGHT UP IN THE RUNNING WITH OUR FOSTER CARE BOARD AND OTHER BOARDS OF COMPARISON? THERE ARE 750,000 SENIOR CITIZENS IN OUR STATE AT THIS TIME. THIS NUMBER IS GROWING AND GROWING AT A PACE THAT SHOULD BE ALARMING TO ALL OF US IN THE FIELD OF AGING. THE BABY BOOMER BRIGADE IS FAST APPROACHING THE ENTRY LEVEL OF THE SENIOR CITIZEN SCENE. THERE WILL BE WELL-ELDERLY, ALONG WITH FRAIL ELDERLY. PROGRAMS AND SERVICES MUST BE AVAILABLE TO BOTH.

THE S. C. ASSOCIATION OF COUNCIL ON AGING DIRECTORS IS PREPARING ITSELF FOR THIS INFLUX OF OLDER PEOPLE. THE ASSOCIATION HAS BEEN ENGAGED IN A STUDY DURING THIS PAST YEAR TO CONDUCT A MARKETING STUDY. ON SEPTEMBER 6, THE S. C. COMMISSION ON AGING APPROVED A DISCRETIONARY GRANT TO ASSIST OUR ASSOCIATION TO FOLLOW THROUGH ON A MARKETING SURVEY TO DO 2 THINGS:

1. TO STUDY THE AWARENESS OF THE 55 PLUS POPULATION ON THE AVAILABILITY OF COMMUNITY SUPPORT SERVICES, AND;
2. TO DEVELOP A MEDIA PACKAGE OF TELEVISION, RADIO, AND NEWSPAPER PUBLIC SERVICE ANNOUNCEMENTS ON AGING ISSUES AND AVAILABILITY OF SUPPORT SERVICES.

THE LATEST STATISTICS REVEALED THAT THE ILLITERACY RATE IN S. C. IS AT 25% OF THE TOTAL POPULATION. OUR ASSOCIATION SEES THIS MEDIUM AS THE BEST METHOD OF REACHING THE TARGETED POPULATION THAT WE SERVE. WE ARE LOOKING FORWARD TO THIS MARKETING PACKAGE AND THE POSSIBILITIES THAT WILL RESULT.

WE HAVE A LOT OF WORK TO DO!!! THE CHALLENGE IS GREAT;BUT IT CAN BE DONE WHEN ADEQUATE PLANNING AND COORDINATION IS PRACTICED AMONG THE VARIOUS PLAYERS IN THE AGING NETWORK. IT MUST BEGIN AT THE LOCAL LEVEL TO BE MOST EFFECTIVE FOR THE COMMUNITIES THAT ARE SERVED.

WE IMPLORE YOU TO PLACE OUR ELDERLY HIGH ON YOUR LIST OF PRIORITIES--- HELP US TO EDUCATE OTHER LEGISLATORS OF THE ISSUES OF OUR AGING POPULATION AND ENCOURAGE AND PROMOTE SERVICE DELIVERY DOLLARS. YOU CAN SEE FROM THE ATTACHMENT THAT LOCAL PROVIDERS ARE DOING A TREMENDOUS JOB IN EXPLORING AND OBTAINING AVAILABLE DOLLARS AT THE LOCAL LEVEL TO EXPAND SERVICE DELIVERY. WE STILL HAVE WAITING LISTS FOR OUR IN-HOME SERVICES (HOME-DELIVERED MEALS, HOMEMAKER, RESPITE, ETC.) --- SERVICES THAT ASSIST IN KEEPING OLDER PEOPLE IN THEIR HOMES INSTEAD OF INSTITUTIONS. WE NEED YOUR HELP, ALONG WITH EVERY LEGISLATOR TO GET ON WITH THE BUSINESS OF THE PLANNING AND CARE OF OUR STATE'S ELDERLY POPULATION.

THE MAIN THRUST OF EVERY LEVEL IN OUR AGING NETWORK IN THIS STATE IS TO PROVIDE PROGRAMS AND SERVICES TO THE ELDERLY OF SOUTH CAROLINA IN ORDER TO ENHANCE THE QUALITY OF LIFE FOR THEM. THE STATE NEWSPAPER RAN A SERIES OF ARTICLES IN MAY. I BROUGHT THESE TODAY TO SHARE SOME OF THE FACES OF SOME OF THE PEOPLE THAT ARE SERVED BY LOCAL COUNCILS ON AGING. HELP US TO HELP THEM. LET'S GET THE AGING BUSINESS IN OUR STATE MOVED UP ON THE SCALE OF PRIORITIES.

AGAIN, WE APPRECIATE YOUR ATTENTION AND CONSIDERATION THAT YOU HAVE ALWAYS EXTENDED TO OUR ASSOCIATION. OUR BEST WISHES TO YOU AS YOU PREPARE FOR A NEW LEGISLATIVE YEAR.

RESPECTFULLY,

Mary Gail Douglas

MARY GAIL DOUGLAS, PRESIDEN
S. C. ASSOCIATION OF COUNCI
ON AGING DIRECTORS

SOUTH CAROLINA ASSOCIATION OF COUNCIL ON AGING DIRECTORS

COMPILATION OF SERVICES/FUNDING AT THE LOCAL SERVICE DELIVERY LEVEL

Services

	SENIOR CENTER	PERSONAL CARE	EMPLOY. REF.	CONGREGATE MEALS
%	78.9	38	38	100
COUNT	30	15	15	38
	EDUCATION	**MEDICAL TRAN.**	**VOLUN. SER.**	**HOME REPAIR**
%	55.3	76.3	57.9	28.9
COUNT	21	29	22	11
	LEGAL SERVICES	**OTHER 1**	**FINANCIAL AID.**	**RESPITE**
%	57.9	55.3	10.5	47.4
COUNT	22	21	4	18

Service Dollars

	PERSONS	UNITS	FEDERAL	STATE
	—	— (% of total revenue)	50.9	5.8
TOTAL: Revenue $	59,980	10,817,746	6,866,580	787,728
	SSBG	**UNITED WAY**	**ACTION**	**IN-KIND**
%:	2.1	4.5	.4	8.3
Total: Revenue $	290,022	607,930	56,266	1,123,439

MARCH 1989 38 COUNTIES RESPONDED TO SURVEY

HOME NURSING	RETIREMENT TRAIN	HOME-DEL. MEALS	TELEPHONE REASSUR
0	10.5	97.4	63.2
0	4	37	24
SHOP/ESCORT	DAY CARE	EMERG. ASSIST.	ESCORT
86.8	7.9	26.3	50
33	3	10	19
OTHER 2	HOMEMAKER	CASE MANAGEMENT	OTHER 3
26.3	94.7	94.7	15.8
10	36	36	6
USDA	GRANT RELAT. INC.	LOCAL	CITY/COUNTY
6.0	4.5	8.9	5.9
811,065	610,867	1,199,384	792,892
MISCELL.	OTHER	TOTAL REVENUE	
2.0	.6	—	
270,932	77,757	13,494,862	

State's population to age faster than nation's

By MICHAEL LEWIS
Staff Writer

If people like Pat Mason have their way, South Carolina will become grayer faster than the rest of the nation.

Mason, executive director of the S.C. Retirement Communities Association, is working with others to promote the state as a haven for retirees, an inexpensive, pleasant and friendly alternative to the traditional retirement in Florida.

But what that will mean for the state has not been determined. No solid research has been done on the economic impact a growing elderly population will have on South Carolina.

The information that does exist paints a mixed picture.

Projections by the S.C. State Data Center show the state's population aging much faster than the nation's. Between 1980 and 2000, the state's over-65 population is expected to increase 84.5 percent, while the number of senior citizens in the U.S. will increase 37 percent.

Many state and local government officials believe that difference could grow as more and more people retire here. Mason notes that each year, 1 million visitors to South Carolina inquire specifically about retirement opportunities.

Many retirees bring with them solid incomes and healthy nest eggs, but some figures suggest the influx might not be such an economic boon.

The last state study examining migration patterns for South Carolina from 1975 to 1980 found disturbing income patterns, says Pete Bailey, chief of health and demographic services with the S.C. Division of Research.

During that five-year period, South Carolina posted a net influx of 6,991 senior citizens, ranking it 11th in the nation in real numbers. Of those people, 4,065 had annual incomes under $10,000, with 3,122 of those having incomes under $7,500. In contrast, only 210 people had annual incomes greater than $50,000, and 2,129 earned between $10,000 and $25,000 a year.

"We were real concerned about what we saw," Bailey says.

George Dick, assistant director of the Central Midlands Regional Planning Council, says, "The first impact of this (retiree) influx may be positive. Then, as these people stay here, they'll get older and frailer, and chronic illness will wipe out their savings.

"Then the state will have to look at paying for their care."

That could be a difficult problem.

Nationally, long-term care for the elderly cost an estimated $50 billion in 1987, according to the Health Insurance Association of America. That cost is expected to increase to $120 billion in 2018.

To make things even more complicated, figures from the U.S. Census Bureau show that for every person 65 or older in 1982, there were 5.3 working-age people. That ratio is expected to drop to 4.7 by 2000, then 2.7 by 2030. That means half as many working people will be supporting government services for the elderly.

If South Carolina's elderly population continues to increase at its faster rate, those ratios will become a reality here much sooner.

Couple that with increased expectations among the elderly, says Ernest Furchtgott, a psychology professor at the University of South Carolina and director of the South Carolina Gerontology Center.

Federal and state officials already are looking at ways to improve services, says Frank Adams, spokesman for the S.C. Health and Human Services Finance Commission.

"It's the nature of the beast that it will be frightfully expensive," he says.

"We'll have to finance it by finding alternative ways and making sure people are placed in the most appropriate setting," he says. "We'll have to look at innovative ways to keep people close to their homes and families."

Linda Stelter/The

S.C. is bringing numbe of retired people to st

Lisa Richter-Moss
Social Service Consultant
P.O. Box 314
Spartanburg, SC 29304

TO: Joint Legislative Committee on Aging

FROM: Lisa Richter-Moss, Social Service Consultant

As a social service consultant in nine long term care facilities in South Carolina, I am coming into contact with a number of residents whose needs are not being met by the current laws regarding the right to a natural death. I would like to present one such case.

A 57 year old female was admitted two years ago into intermediate care with a primary diagnosis of Alzheimer's disease. On admission she could no converse in complete sentences or make any decisions on her own. She became easily frustrated and spent most of her time walking. At that time her facial expressions were very clear and easy to read. She liked being around staff and around her uncle.

She had known of her diagnosis for almost three years prior to this admission and had been slowly deteriorating. The factory where she was manager of quality control had been able to continue her employment by reassigning her to more routine tasks. Within 6 to 8 months she could no longer live or work independently. For the next three years she lived with various family members until no one could manage her care.

In preparation for what was to come she gave her power of attorney to her uncle. Since then he has managed her affairs very admirably. She continues to pay privately for her care through him and he meets all her material needs. He has also been very emotionally supportive of her. She chose her uncle well. He refused her desire to list him as a beneficiary in her will as he wanted no conflict of interests to develop. But recently it has become very difficult for him to watch her continued deterioration.

She no longer knows her uncle when he visits. She no longer walks or laughs or cries. She expresses her frustrations now by pulling out her hair and picking at her skin. She fluctuates between being spoon fed and tube fed according to her needs.

Recently, her uncle and other family members decided that the time had come to establish her as a "No Code" status (a term used by hospitals to indicate no heroic life saving measures are to be used). In this way they hoped to allow her disease to take its natural course without the interference of medical technology. They discovered that only she had the power to do that through a living will or a declaration of the right to a natural death. She had not prepared for that, and now it is too late.

This resident, like many others in our nursing facilities, has lost her right to a natural death. She probably thought that giving her uncle the power to handle her affairs and make her decisions would be sufficient to take care of her, in the manner in which she would chose, for as long as she lives. Her uncle has the power and the responsibility to make all her decisions for her. And yet this decision is not within his power and therfore it is not within her power.

We need more alternatives available to meet the needs of our elderly. They need to be made aware of this issue so they will consider a living will while they are competent to do so. For those who are already incompetent and gave their durable power of attorney to someone else, we should honor that persons decision making powers. Still we have a large number of residents who never gave their power of attorney to anyone. Their needs require consideration too.

Respectfully Submitted,

Lisa Richter-Moss, LBSW

9/20/89

Carol Reis, Executive Director
Finlay House
2100 Blossom St.
Columbia, SC 29205

FINLAY HOUSE
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CAROL A. REIS, *Executive Director*

REMARKS AT PUBLIC HEARING - September 20, 1989

Chairman Harris and Other Distinguished Members of the Joint Legislative Committee on Aging:

Good afternoon. Thank you for giving me an opportunity to share my concerns with you today.

My name is Carol Reis and I am Director of the Episcopal Housing Corporation which operates Finlay House here in Columbia. Just in case you do not know what Finlay House is, its an apartment community for 220 older pople which encourages independent living and provides some innovative support services.

My presence here this afternoon may be unique - - I'm not asking for any money nor am I protecting any turf. I merely want to briefly share two concerns and observations that I have had as a taxpayer and a person who cares about older people.

My first concern is transportation for the elderly. The agencies presently providing transportation services to the elderly suffer from lack of money and lack of trained transportation specialists. As a result, most of the transportation being provided in this state is transporting older people back and forth to nutrition sites. This is very costly and ineffective. But more importantly, most elderly who really need transportation, go without. We already have a sophisticated transportation program operating in every county of this state transporting handicapped school children. This system is not being utilized at the very times that the elderly need transportation (between 9:00 A.M. and 2:00 P.M.). Back in 1983, when I sat on the Governor's Resource Panel on the Elderly, we recommended that state owned minibuses used by local school districts be available to transport older people. However, at that time, students were being used as bus drivers so that implementation of this recommendation would have been difficult. Now that that obstacle has been removed, isn't it time to use the handicapped minibuses to transport our older people to needed services? The funds currently being wasted on inefficient transportation programs for the elderly could be transferred to the school districts to expand their transportation programs to include the elderly. This would provide an expanded, sophisticated, and far more efficient system for the same dollars.

My second concern is the frail elderly - that population that needs the most care and services and costs the most dollars - yet we have no way of planning for them. I remember the Resource Panel members' frustration as we tried to identify the frail elderly - - Who were they? What were their needs? Where did they live? How many were there? Every agency who serves the elderly - Mental Health, Social Services, Health and Environmental Control, Health and Human Services, Councils on Aging and others - has data on the frail elderly. Unfortunately, planners have no way of knowing how many of these agencies are serving the same people. The problem is the assessment tool and each agency's reluctance to agree to some uniformity so that data can be shared. Each agency has a form that they complete when an elderly client first enters their system or applies for services - - this form is called an assessment form. Each agency has developed its own assessment form which is different from any other agency's form and as a result, the information gathered cannot be shared statistically with other agencies and elderly clients cannot be tracked. Moreover, agencies serving the elderly waste time and energy duplicating the assessment service when this has already been done by another agency. It is possible that one frail older person could be receiving services from as many as five different agencies unbeknown to the others. I had one lady at Finlay House who was receiving physical therapy from DHEC, had a Homemaker from the COA, was getting counseling through DMH and had been assessed by CLTC for nursing home placement. I hear some pretty scary figures about the number of frail elderly in some communities - - I can't help wondering if we are not counting that same frail older person two or three times because we have no way to acquire accurate statistics. If we are planning future services based on current statistics, we may waste a lot of money.

In 1983, the Resource Panel's study of agency data revealed that a clear picture of the number of elderly needing service, the unduplicated numbers being served, and the number requesting service could not be obtained. Here it is six years later and my understanding is that the problem still has not been resolved. It seems to me that a lot of time and money currently being spent by each agency assessing clients could be used for services if a standardized assessment tool would be accepted and shared by all. I am not a computer expert but I just have to believe that if the agencies serving the elderly cannot agree on a standardized assessment form, there has to be a way to identify certain fields on each agency's assessment form that would allow for a way to develop an accurate data base for targeting, planning services and exchanging information. The time is long overdue for agencies to get together and accomplish this task. Maybe a bit of urging from this Committee will help.

In closing let me say that my comments are not made today to criticize the agencies who try so hard to serve the elderly but simply to improve on these efforts. As a citizen of South Carolina who may get old and frail, I want to have appropriate services available to me when and if I do. As a tax payer, I want these services planned based on accurate statistics so that my money is not wasted.

Thank you for listening to my concerns and recommendations.

Carol A. Reis

Harris - **Thank you, Miss Reis. Are there any questions?**

Blackwell - **You do us a service by telling us those things.**

Harris - **We appreciate it. Moving on the next presentator is Dr. Daniel Brake, President of SC Medical Association.**

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PUBLIC HEARING, JOINT LEGISLATIVE COMMITTEE ON AGING
TESTIMONY: PERSONAL CARE PROGRAM
DANIEL BRAKE, M.D.
PRESIDENT, SOUTH CAROLINA MEDICAL ASSOCIATION

GOOD AFTERNOON. I'M DR. DAN BRAKE, PRESIDENT OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. I AM DELIGHTED TO BE HERE TODAY TO SHARE SOME GOOD NEWS WITH YOU. ALTHOUGH MANY OF YOU ARE PROBABLY AWARE OF THE MEDICAL ASSOCIATION'S PERSONAL CARE PROGRAM, WE NEED TO CONTINUE TO SPREAD THE WORD TO ALL MEDICARE BENEFICIARIES SO THAT ALL ELIGIBLE PERSONS MAY BENEFIT FROM THE PROGRAM.

VERY BRIEFLY, THE PERSONAL CARE PROGRAM WAS DEVELOPED AND IMPLEMENTED EARLY THIS YEAR BY THE MEDICAL ASSOCIATION FOR THE PURPOSE OF ASSISTING THE MANY FINANCIALLY NEEDY MEDICARE PATIENTS IN SOUTH CAROLINA. OVER 900 NON-PARTICIPATING PHYSICIANS, OR ONE-QUARTER OF THE NON-PARTICIPATING PHYSICIAN POPULATION IN SOUTH CAROLINA, HAVE ENROLLED IN THE PERSONAL CARE PROGRAM. UNDER THE PROGRAM, THESE PHYSICIANS AGREE TO ASSIST MEDICARE PATIENTS BY: (1) EXPLAINING BILLING AND PAYMENT ARRANGEMENTS; (2) ASSISTING PATIENTS IN FILING CLAIMS AND OBTAINING PROPER REIMBURSEMENT; AND (3) MAKING SPECIAL PAYMENT ARRANGEMENTS FOR PATIENTS EXPERIENCING FINANCIAL DIFFICULTIES.

IN DETERMINING WHICH MEDICARE PATIENTS ARE TRULY FINANCIALLY NEEDY, THE LOCAL COUNCILS ON AGING, OR AGING SERVICE PROVIDERS, LOCATED THROUGHOUT THE STATE ARE ASSISTING IN THE PROGRAM BY

ACCEPTING ONE-PAGE APPLICATIONS FROM INTERESTED MEDICARE BENEFICIARIES AND MAKING ELIGIBILITY DETERMINATIONS BASED ON THIS INFORMATION. FOR EXAMPLE, AN INTERESTED MEDICARE PATIENT CAN GO BY THEIR LOCAL AGING SERVICE PROVIDER OFFICE AND COMPLETE A SHORT, ONE-PAGE APPLICATION ON INCOME AND CURRENT HEALTH INSURANCE COVERAGE. MEDICARE BENEFICIARIES WITH AN ANNUAL INCOME OF 150% OF POVERTY, WHICH IS $8,250 FOR A ONE-PERSON FAMILY OR $11,100 FOR A TWO-PERSON FAMILY, WITH NO HEALTH INSURANCE OTHER THAN A MEDICARE SUPPLEMENT QUALIFIES. IT'S AS SIMPLE AS THAT. HE OR SHE WILL BE ISSUED A WALLET SIZE PERSONAL CARE CARD WHICH MAY BE PRESENTED TO ANY NON-PARTICIPATING PHYSICIAN, PARTICULARLY THOSE ENROLLED IN THE PERSONAL CARE PROGRAM. PATIENTS WHO EXCEED THESE GUIDELINES BUT HAVE SPECIAL FINANCIAL NEEDS MAY REQUEST THAT THE AGING SERVICE PROVIDER REPRESENTATIVE WRITE A LETTER TO HIS OR HER NON-PARTICIPATING PERSONAL PHYSICIAN, EXPLAINING THE SITUATION AND URGING THE PHYSICIAN TO ACCEPT ASSIGNMENT ON THIS PATIENT UNTIL HIS OR HER FINANCIAL SITUATION IMPROVES.

LET ME GIVE YOU AN EXAMPLE OF MEDICARE REIMBURSEMENT FOR A TYPICAL FAMILY PRACTICE PHYSICIAN IN SOUTH CAROLINA THIS YEAR. ACCORDING TO PRIVATE INSURANCE COMPANIES, A FAMILY PRACTICE PHYSICIAN MAY CHARGE PRIVATE PAY PATIENTS $28.00 FOR AN OFFICE VISIT. WHEN A TYPICAL FAMILY PHYSICIAN AGREES TO ACCEPT ASSIGNMENT, HE OR SHE WILL BE REIMBURSED SLIGHTLY OVER $10.00 FROM MEDICARE AND THE PATIENT WILL BE RESPONSIBLE FOR APPROXIMATELY $2.00. A PHYSICIAN WHO DOES NOT ACCEPT ASSIGNMENT UNDER MEDICARE MAY CHARGE UP TO $22.44, OR THE MAAC, THUS MAKING THE PATIENT RESPONSIBLE FOR THE DIFFERENCE BETWEEN WHAT IS

ACTUALLY CHARGE AND WHAT MEDICARE REIMBURSES, WHICH IN THIS EXAMPLE IS ALMOST $12.00.

CLEARLY PHYSICIANS WHOSE PRACTICE IS MADE UP PRIMARILY OF MEDICARE PATIENTS CANNOT AFFORD TO KEEP THE DOORS OPEN IF HE OR SHE ACCEPTED ASSIGNMENT ON ALL PATIENTS WHETHER THEY ARE FINANCIALLY NEEDY OR NOT. THE INCOME GENERATED, WHICH WAS $12.00 PER VISIT IN THE EXAMPLE I GAVE, IS SIMPLY NOT ENOUGH TO MAKE IT FINANCIALLY FEASIBLE TO COVER EMPLOYEE PAYROLL, RENT, UTILITIES, MEDICAL EQUIPMENT AND SUPPLIES, ETC. AS YOU CAN SEE FROM THESE FIGURES, IT IS SIMPLY NOT POSSIBLE FOR SOME PHYSICIANS, SUCH AS FAMILY PRACTITIONERS, TO AGREE TO ACCEPT ASSIGNMENT FOR ALL MEDICARE PATIENTS.

IN ADDITION, MEDICARE PHYSICIAN FEES WERE FROZEN IN 1984 AND SINCE THEN MOST PHYSICIANS HAVE BEEN ALLOWED ONLY A 2% INCREASE IN THEIR MEDICARE FEES. FOR EXAMPLE, I CHARGED $22.00 FOR ALL PATIENTS IN 1984 AND IN 1989 I CHARGE $28.00 FOR PRIVATE PAY PATIENTS AND ONLY $22.44 FOR MEDICARE PATIENTS.

HOWEVER, THAT'S NOT TO SAY THAT PHYSICIANS ARE NOT INTERESTED IN ACCEPTING ASSIGNMENT ON THOSE PATIENTS WHO ARE TRULY NEEDY. IT SIMPLY MEANS THAT THE MANY SOUTH CAROLINA CITIZENS OVER 65 YEARS OF AGE WHO RECEIVE MEDICARE, SUFFER NO FINANCIAL HARDSHIPS, AND ARE FINANCIALLY ABLE TO PAY THEIR MEDICAL BILLS IN FULL SHOULD DO SO. IT'S THE NEEDY MEDICARE PATIENT WE ARE CONCERNED WITH HERE; THAT'S WHY THE SOUTH CAROLINA MEDICAL ASSOCIATION IMPLEMENTED THE PERSONAL CARE PROGRAM TO DETERMINE EXACTLY WHO THESE NEEDY PATIENTS ARE AND TO HAVE A CONCERTED EFFORT TO BETTER MEET THEIR NEEDS.

SOUTH CAROLINA IS CONSTANTLY CHANGING, AND THE NUMBER OF OLDER SOUTH CAROLINIANS IS INCREASING RAPIDLY. IN ADDITION TO THE AGING OF OUR OWN CITIZENS, PERSONS ARE RETIRING TO SOUTH CAROLINA AT THE THIRD HIGHEST RATE IN THE COUNTRY. WE CURRENTLY HAVE 500,000 PERSONS OVER 60 YEARS OF AGE AND 350,000 PERSONS OVER 65 YEARS OF AGE WHO ARE ELIGIBLE FOR MEDICARE. IT IS ESTIMATED THAT BY THE YEAR 2010, A MERE 20 YEARS FROM NOW, ONE MILLION PERSONS OVER 60 YEARS OF AGE WILL CALL SOUTH CAROLINA HOME.

WITH THIS ASTONISHING FACT AND DECREASING AVAILABILITY OF HEALTH CARE DOLLARS, WE MUST ALL BEAR IN MIND THAT WE ARE GOING TO HAVE TO WORK TOGETHER TO ASSURE THAT ACCESSIBLE AND AFFORDABLE QUALITY HEALTH CARE IS AVAILABLE FOR ALL SOUTH CAROLINIANS REGARDLESS OF FINANCIAL ABILITY TO PAY. THOSE WHO CAN AFFORD TO PAY THEIR MEDICAL BILLS IN FULL OR PAY INSURANCE PREMIUMS MUST DO SO THAT WE MAY PROVIDE AFFORDABLE, QUALITY MEDICAL CARE TO THOSE WHO CANNOT.

IF YOU THINK YOU OR SOMEONE YOU KNOW WOULD QUALIFY FOR THE MEDICAL ASSOCIATION'S PERSONAL CARE PROGRAM, BE SURE TO GO OR HAVE YOUR FRIEND GO BY YOUR LOCAL AGING SERVICE PROVIDER TO FILL OUT AN APPLICATION. THE BENEFITS OF THE PROGRAM CAN REALLY MAKE A BIG DIFFERENCE FOR THOSE IN NEED.

THANK YOU.

Harris - Dr. Brake, thank you very much. Are there any questions?

McLeod - What percent of the physicians participate in this Personal Care Program?

Brake - Well let me explain to you. In the Personal Care Program we have approximately 40% of the physicians in S.C. that are participating physicians. About 950 physicians have signed up for the Personal Care Program but we didn't ask the participating physicians to sign up because they are already participating. So what we have asked, is the nonparticipating physicians to sign up in the Personal Care Program.

McLeod - You mean of those that don't participate in Medicare.

Brake - Right.

McLeod - What percent take the Medicare assignment?

Brake - It's complicated because #1 we can't get the figures on how many physicians in S.C. are truly participating. Blue Cross/Blue Shield are the Medicare administrator. They sent out a form and the physician signs the form saying he is a participating physician. That goes back to BC and there may be a group that's participating which may have 5 or 10 doctors in it or may have 2 doctors or may be an individual physician. When we sent out a form to try to get the personal care physicians, we didn't know who was participating and who wasn't. So we sent forms out to all physicians in the state and we said if you aren't a participating physician we would like you to sign this form and become a personal care physician. I have to tell you a couple of things. There are a number of physicians in S.C. that don't see Medicare patients such as Pediatricians. We are working on getting the number.

McLeod - We have to participate in Medicare if you are going to practice Medicine in that state. I had the impression that we had a very high percentage now that had agreed to do it. Apparently that's inaccurate. If ya'll can't give us some figures, surely the General Assembly can get them.

Brake - Well, if you can get BC to find us the number of physicians that are participating, then we can add the personal care physicians in there and then we can tell you what percentage of physicians in the state will accept assignment on needy patients.

McLeod - The Personal Care program is going to address those people who have got the problem. I've got no problem with someone whose got money paying but if we still don't know. Mr. Chairman, will you see whether staff can get the number of participating physicians. If BC won't give it we will do something legislatively to acquire it.

Harris - Yes sir.

Brake - The other thing I might point out to you is that before our Personal Care Program over 70% of all Medicare claims physicians accepted assignments. Obviously, for me as a family physician to assign and say I'm a participating physician would mean have to accept $12 an office visit on all Medicare patients that came in my office and that would not cover overhead. So I can't do that but what I did do was that when a Medicare patient came in that I knew had financial problems I just accepted assignment. The good thing that has happened to me on Personal Care Program is that I had a couple of older patients that I didn't realized had financial problems and they walked in and said I've go this card. I had been changing them my maximum charge which was my 1984 fees but they still had been paying that. I didn't know they had a financial problem so when they showed me the card I could say I'm glad to know that you need this help. This card helps us identify those people and before they walked in and were struggling to pay their bill and not letting us know.

McLeod - Did you say 40% is nonparticipating? Is that increasing? That sounds like you are making progress.

Brake - We had 700 physicians and we've got 950 now. I'm going to every county with the Medical Society in the state and I'm telling the physicians to go ahead and let's get on the personal care program because even a number of them that aren't with the program yet are still accepting assignment because we would not have over 70% of the claims accepting assignment if we didn't have more than 40% of the physicians participating in the needy care.

McLeod - It's too complicated for me.

Brake - It is for me, too. Medicare is extremely complicated.

Blackwell - Doctor, I wanted to make some comments along another line. I don't want to see you take a loss. But I want you to be an advocate for the older folks. Since 1966 people of S.C. have paid exactly the same premium for Part B coverage under Medicare that people of Pennsylvania, New York, Michigan, or anywhere else have paid. The doctor bills which have been reimbursed in those other states have been paid with our premiums to some extent. We are treated differently because we are from S.C. and because you folks had a lower profile. Now, I want your Association to take a stand with our Congressional delegation and say either go to a flat fee across this country or reduce the premiums that the older folks are paying for Part B in S.C. If we are going to be reimbursed at less money then our premiums should be less money. I would like very much for you sir, this year in your organization to make it abundantly clear to the Congress that you think your patients are being treated unfairly. Then I want to say to the people that are here that are listening to this right now that those of you who want to sue somebody go into the federal court and sue the Medicare folks. So let's get our fair break there. Now you talk to me about suing the state. you have sat still since 1966 and paid the same price for what folks all over the country get and you don't get your share. I'm sorry to get on a soap box but I think that's important.

Brake - We appreciate that. We are on the soapbox because we have taken this to the AMA and to our state delegation. We appreciate your support on that. I can assure you that you will see another letter from me to our S.C. delegation and hope that you will support us in trying to get this corrected in S.C.

Lourie - I want to commend the Medical Association for the Personal Care Program. That's a good step. Early we had testimony that there was a problem finding doctors to treat Medicaid patients.

Brake - In 1964 I went into medicine because I had an uncle who was an old general practitioner. I worked with him for a long time and he saw everybody that walked in the door. Some paid him corn, some people paid him nothing and some people paid him in full. In 1965 we got Medicare and Medicaid and what happened was we started getting involved in having to fill out paperwork and sending in forms. I don't know if you remember in the 70's the state decided to take over the funding or financing of Medicaid as far as a claims payment was concerned and shifted to computers. They said July 1, they

would be ready to take care of it. It was 3 to 6 months before and doctors received payments from Medicaid. So doctors had as much as $30,000 or $40,000 on the books and had to go to the bank to borrow money. Anyhow to make a long story short, there were alot of problems in dealing with Medicaid itself. The Medical Association has worked very hard with Medicaid. I would tell you that they've worked very hard with us. And over the past year we have been able to see that we are going to have a decrease in the paperwork. There has also been an increase in reimbursements. In fact in the state, you can treat an indigent patient for Medicaid and get more for an office visit than you can treating Medicare patients and accepting assignment. It is about 60-70% more. At the present I'm telling each county that we have worked to try and improve the paperwork and worked to improve the reimbursements and now you have given us the ball to get the physicians to participate. That's where we are heading with it.

McLeod - Do we a have a percentage on that?

Brake - No, you don't have to sign to participate in Medicaid forms. So nobody has got any record of this.

Harris - Thank you, doctor. The next presentator is Dr. Michael Stogner, Aging Unit Director of SC Appalachian Council of Governments.

Mr. Michael Stogner
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PUBLIC HEARING TESTIMON

JOINT LEGISLATIVE COMMITTEE ON AGING

September 20, 1989

Rep. Harris, Members and staff of the Joint Legislative Committee on Aging, my name is Michael Stogner. I am the Aging Unit Director of the Appalachian Council of Governments. I am not here today representing any particular association or group, rather am speaking as an individual.

I wish to express my sincere gratitude to each of you for your exemplary leadership and hard work on the behalf of the older citizens of South Carolina. There is not one older South Carolinian whose life has not been postively touched in some way by your efforts. I look forward to working with you in the upcoming session in our continuing endeavors to insure the highest quality of life for our older citizens.

You have heard in previous testimony the Commission on Aging's budget request and supporting rationale. There are several priorities that I would like to especially encourage you to support: the annualization of the cost of living increment for service providers; the restoration of the previous reductions in State Grant Funds for the Planning and Service Areas; the request implementing the findings of the General Assembly directed survey determining the need for improving current Senior Centers and establishing Senior Centers in those countys which do not have one; and, the request to strengthen the area agencies on aging, increase in-home services for frail older persons, and increase training funds.

As you know, there have been several initiatives related to the need for a continuum of care for older South Carolinians in need of long term care services. An integral component of this continuum is the necessity for services and incentives which support those caring for the frail elderly at home. The development of more in-home services as alternatives to institutional care should be supported, and the tax credit legislation for families who provide such care should be passed. Also our system would be strengthened with the addition of residential care facilities which provide a full range of housing and personal care services.

I wish to thank you for efforts in helping secure the allocation of more funds for 1,500 additional medicaid sponsored nursing home beds. In an effort to make these beds available faster, I would encourage your complete review of the Certificate of Need process to see if it can be streamlined - including perhaps requiring those who wish to appeal the DHEC bed awards to post a sizeable bond.

In 1987 The General Assembly increased the state gasoline tax and 1/4 of one cent was earmarked for public transportation activities. A portion of these dollars were designated to purchase vans for those agencies serving the lederly and handicapped community. I would encourage your support of efforts to annualize these funds to the Division of Public Transportation (perhaps through the interest accured on the state gasoline tax) and stipulating that a portion of the funds must be used for capital equipment expenditures for those serving the elderly and handicapped.

Further support should be given to: exempting cords and batteries for hearing aids from sales tax; allowing dental hygenists to perform preventive services in nursing home settings to the "dentally indigent" increasing the homestead exemption either across the board or through the indexing/circuit breaker approach; health care/durable power of attorney (medical) legislation when it presented to you and is addresse in Eve Stacey's remarks (S. C. Bar Assoc.); thorough review of the regulations implementing Act 97 , Continuing Care Retirement Community Licensing Act, to assure the protection of older citizens who purchase living arrangements through life care communities; mobile and modular home park tenancy act. I would request that while the State Insurance Department is monitoring the implementation of the Long Term Care Insurance Act regulations to insure quality products and compliance with the regulations, that they review the state employee Long Term Care policy to ensure that it is in compliance with the regulations.

Most of the above concerns cannot be adequately addressed for the present, much less the future, generation of older South Carolinians without a commitment of substantial resources. I would suggest that it is time to allow the citizens and tax payers to have the opportunity to amend the Constitution authorizing a state lottery, if such were to be the vote results, along the lines of S.180.

Again, thank you very much for this opportunity to share my concerns regarding issues that effect the older citizens of South Carolina.

In closing I would like to encourage your attendance at both the SCFOA's and Gerontological Society Annual meetings. Also, as some of you know, the Appalachian Council of Governments Area Agency on Aging is a member of the Southeastern Association of Area Agencies on Aging. As such we have the opportunity to submit nominees for several awards that SE4A annually awards. One of the awards annually presented by SE4A at the annual conference is the "Excellence in Aging" Award. This award recognizes the outstanding contributions of an individual outside of the Area Agencies on Aging who promotes the safety, welfare, and weel being of the elderly. The award will be presented at our meeting in Huntsville, Alabama, October 23, 1989. I am proud to announce that this year's recipient of the SE4A "Excellance in Aging" Award is none other than Rep. Patrick B. Harris. On behalf of the entire aging network, congratulations Mr. Pat.

Harris - **Any questions of Mr. Stogner? I'm not going to ask you how I got that. I'm very grateful and I appreciate it but I hope I deserved it. I must ask to be excused and ask Representative Blackwell if he will preside in the absence of the Vice-Chair.**

Blackwell - **Our next presentator is Tim Harbeson with Legal Division of Ombudsman Office with the Governor's office.**

Tim Harbeson
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Comments to the Joint Legislative Committee on Aging
Timothy D. Harbeson, Ombudsman Division
September 20, 1989

Mr. Chairman and Committee members, thank you for allowing me the opportunity to make this presentation to you. My name is Tim Harbeson and I am the Deputy Director and Legal Counsel for the Ombudsman Division of the Governor's Office. I want to briefly discuss with you an issue which the Division considers to be a gap in our State law. That is, a need for defining "neglect" and "exploitation" in the Client-Patient Protection Act, Chapter 30 of Title 43 in the South Carolina Code of Laws. This Committee has been instrumental in the history of this law which is intended to protect a very vulnerable segment of society; the residents of nursing homes, adult residential care facilities, and similar residential institutions.

Part of the function of the Ombudsman Division is to investigate complaints of these residents. Thus, we have a common interest in this population. It is because of the Division's experience with actual cases in which the lack of the definition of "neglect" or "exploitation" has impacted on our function that I am here today.

The purpose of the Client-Patient Protection Act as set out in Section 30 states:

> Recognizing that client-patients need protection, it is the purpose of chapter to save them from injury and abuse by establishing an effective reporting system and encouraging the reporting of client-patients in need

of protection; by establishing fair and equitable procedures compatible with due process of law with due regard to the safety and welfare of all persons and by establishing an effective system of protection of client-patients from injury and abuse while living in public and private residential agencies and institutions.

The Act defines such terms as "abuse and neglect", "abuse", "threatened abuse", and "physical injury". However, the Act fails to define the terms "neglect" and "exploitation". It is certainly in keeping with the Act's purpose, especially in light of a real life example such as the one I am about to share with you, that both neglect and exploitation be defined.

Ms. Doe was a resident of X Adult Residential Care Facility. Our office was contacted by a home health nurse who visited the facility to provide decubitus (bed sores)care for the resident. (Decubitus ulcers occur when there is unrelieved pressure on a bony prominence.) In accordance with the physician's orders, the nurse had trained the facility staff in caring for the decubiti which included changing the dressing on the resident's foot four times a day. During a subsequent visit, she noticed that the dressings were filthy and had not been changed. The resident's medications for treatment of the decubiti were not secured and the facility failed to take the resident to follow-up physician visits. (The foot, in effect, had begun to rot.) The nurse arranged for the resident to be taken to the physician's office. The physician immediately admitted the resident to the hospital for removal of the dead tissue and possible amputation. It should be noted that the resident's functioning level was such that she was unable to provide her own decubitus

care. In the absence of a definition of neglect in our law, we had no means by which to cite the facility in this case.

Further, it is important to emphasize that both an Assistant Attorney General and an Assistant Solicitor to which this case was referred by the Ombudsman investigator also determined no criminal action was possible under the existing code sections.

I also want to point out that the situation concerning exploitation, while not involving physical consequences to the victim, is nonetheless an injury to which the Act should supply protection. A large number of long-term care facility residents are vulnerable to exploitation because of physical or mental impairments which necessitate them being in the facility.

I have drafted language to propose as amendments to the Client-Patient Protection Act to rectify these gaps in the law. The definitions are included in the written material I have submitted. The language is a composite of definitions found in state and federal law and regulations. Although I have submitted specific suggestions I realize some changes may be desired by the Committee and by other members of the General Assembly. However, some definition is needed for these terms which is at least as comprehensive as what I have submitted. I appreciate your consideration and will be happy to answer any questions you may have now, or if you think of them later my office phone number is 734-0457.

Blackwell - Thank you, Mr. Harbeson. We need all the help we can get. I was going to ask you to have Mark draw it. I appreciate you going ahead and preparing this for us.

Harbeson - I submitted those to Mark yesterday with his approval.

State of South Carolina
Office of the Governor

CARROLL A. CAMPBELL, JR.
GOVERNOR

OFFICE OF EXECUTIVE
POLICY AND PROGRAMS

- MEMORANDUM -

TO: Keller Barron

FROM: Tim Harbeson

RE: Amendments to the Client-Patient Protection Act

DATE: August 9, 1989

Maria Patton discussed with you the desire of the Ombudsman Division to have the Client-Patient Protection Act amended to include definitions of "neglect" and "exploitation". Below are the definitions which have been developed from various state and federal statutes.

We would appreciate an opportunity to be on the agenda of the Joint Legislative Committee on Aging to present these proposed amendments. Please call Maria or myself at 734-0457 if you have any questions.

43-30-20(J) -
Neglect of a client-patient's health or welfare may occur when the person responsible for his welfare fails to provide the goods or services which are necessary to avoid physical harm, mental anguish or mental illness or such responsible person allows the failure to occur. Examples of neglect include, but are not limited to, failure to provide adequate food, shelter, health care, safety, or clothing, or failure to notice the patient's condition and take appropriate action.

43-30-20(K) -
Exploitation means an illegal, improper, or unjust act or process of a facility administrator or staff member using the resources of a client-patient for monetary or personal benefit, profit, or gain.

43-30-100(1) -
It is unlawful for any person to neglect, exploit, abuse, threaten to abuse, or cause physical or mental injury to any client or patient, as defined in §43-30-20.

TDH:o

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Elaine Marks, Legislative Chair
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The South Carolina Retired Educators Association

421 Zimalcrest Drive Columbia, S.C. 29210 Phone 772-6553

1. Benefits for Low Income Retirees. A concern of the Retired Educators Association is the segment whose benefits are very low. These persons' salaries were low (at the bottom of the list nationally) which meant their retirement contributions were low. This, in essence, has left teachers who spent their career years in this system with an income below poverty level.

We ask for your assistance with the State Retirement System to help us in solving this dilemma.

2. Health Benefits. This has become a crisis.

a. Every member of the State Insurance System has to re-enroll during October. We urge the new Insurance Division to use every media avenue possible to ensure that retirees get this information and are re-enrolled. Also, the Insurance Division is going to assume that all Social Security recipients have Part B of Medicare. When a claim is paid which involves the kinds of services covered by Part B, they will deny the claim. This would mean that the many who cannot afford Part B are now individually liable. This is a major concern.

b. We are urging that premium increases be kept to a minimum. Retirees were led to believe at retirement, that this would not be a problem. One illness could wipe out a retiree's income.

3. Homestead Exemption. We appreciate the passage of the increase last year, and hope it can be funded next year.

SOUTH CAROLINA RETIRED EDUCATORS ASSOCIATION

1989-90 LEGISLATIVE PROGRAM

1. **Retirement Benefits for Low Income Retirees**

   For those who had taught at least 20 years and whose salaries were such that their retirement is below the poverty level, we are working to improve their monthly retirement benefits to an acceptable standard of living.

2. **Health Benefits**

   We urge the General Assembly to keep health benefits at the current level and any premium increase be kept to a minimum.

3. **General Legislation for Retired Persons**

   To keep abreast, informed and alert to the general needs of the elderly, and to promote legislation beneficial to this group.

4. **Homestead Exemption**

   We ask that the Homestead Exemption for homeowners 65 years of age and above be increased from the current $25,000 to $30,000 and we urge the General Assembly to fund this program.

5. **Support for Public Education**

   The members of the SCREA, having invested many years of their lives promoting public education, continue to support advancement and improvement of public education in South Carolina.

Preston H. Callison, General Cour
P.O. Box 6009
W. Columbia, SC 29171-6009

STATEMENT OF THE SOUTH CAROLINA HOSPITAL ASSOCIATION

presented to the

JOINT LEGISLATIVE COMMITTEE ON AGING

by

Preston A. Callison, General Counsel

September 20, 1989

Mr. Chairman and members of the Committee, my name is Preston Callison. I am the South Carolina Hospital Association's General Counsel. I appreciate the opportunity to be here today to discuss with you the Hospital Association's concerns regarding the growing elderly population.

SCHA strongly believes our elderly citizens should be encouraged and assisted in leading independent, productive lives for as long as possible. SCHA has been working with the Commission on Aging and it's Council on Elder Affairs and other concerned organizations and we fully support the priority goals identified by the Council on Elder Affairs earlier today. I would like to detail a few other related concerns.

Many of these concerns were identified during the Healthy Future for South Carolina Study, initiated by the Hospital Association in 1988. While the study was very broad-based, one task force focused on the special needs, or segments of our populations, such as the very young and senior citizens. Government, business, insurance, providers, educators and consumers were represented as problems were identified and recommendations to address those problems were made. A report was published in May of 1989 and has been distributed throughout the state to interested groups.

Today, I would like to mention a number of recommendations from that study that also relate to the priority goals the Council on Elder Affairs has identified.

Certainly, an adequate Medicare program is important to all of us. It's important to our senior citizens living on fixed incomes, who rely on it for their health care services. It's also important to our soon to be senior citizens who expect to rely on it in a few years. It's important to the children, friends, and neighbors of senior citizens who are the cornerstone of care for the frail elderly. It's important to employers who pay the unpaid portion of Medicare bills through a cost-shift to privately insured patients. And it's important to hospitals and other providers, as partners with the state and federal governments in providing care.

While decisions regarding Medicare are made at the federal level, it is critical for you, as state leaders to understand the problems associated with an inadequate Medicare program and urge our Congress to promise to protect Medicare in FY 1991 budget deliberations.

Last year, you made a major commitment to improve the state's Medicaid program. As a result more South Carolinians will be able to access the system more easily and the financial burden on individuals and their employers, who share the cost of their care, has been lessened.

However, today our inadequate Medicare program represents an even more serious drain on consumers of health care and potentially threatens access to all our citizens. I think you can easily appreciate the connection when I tell you that Medicare covers almost 40 percent of hospital patients across the country. Yet the average hospital's Medicare payments are eight or nine percent less than the hospital's costs. Unless adequate Medicare funding is provided by Congress hospitals will be forced to drastically cut services to the elderly and some hospitals face the real possibility of closing since the unsponsored patients can no longer carry this increased burden which is driving up hospital rates with the resultant inordinate increase in health insurance.

The American Hospital Association has begun its next phase of a national Medicare advocacy campaign to affirm the need for fair Medicare funding in the budget that the Bush Administration will submit to Congress in January. On the occasion of Medicare's 25th anniversary, every hospital family will be asked to write to Congress and the White House before December 1 urging Congress and President Bush to "keep the promise" to provide high quality health care for the nation's elderly and disabled. We urge you to do the same.

Secondly, we need to work together to increase public awareness of special problems of the elderly and create incentives for development of programs to meet those needs, such as adult day care centers, respite care, personal care, transportation and nursing facility development.

During the last legislative session some of the regulatory barriers were removed to allow more skilled nursing home beds to be built and to allow rural hospitals to convert empty capacity to nursing home beds. Many of our rural hospitals have begun to respond to this opportunity but face the problem of inadequate reimbursement. SCHA is in the process of surveying them regarding what they are planning in this area and what additional barriers could be removed to facilitate this process. We will share the results with you.

Lastly, we urge you to consider ways to encourage employers to provide adequate health benefits and pension plans, as well as financial planning assistance to help employees avoid impoverishment in later years.

We welcome this opportunity to discuss our mutual concerns related to our growing elderly population. SCHA pledges our support and assistance as we all work together to help our seniors maintain their dignity and independence. Thank you.

Blackwell - We appreciate that and we are glad that they kept you alive, too. We appreciate the Hospital Association and the way it works with the General Assembly. You can bet this is one of the items we will want to consider as we look at this testimony. Thank you very much. We will now hear from the SC Federation of Older Americans by Herbert Weisberg.

Herbert Weisberg, Chairman
Legislative Forum - SC Federation
for Older Americans
1000 Quail Run
Columbia, Sc 29206

Mr. Harris, ladies and gentlemen of the Joint Legislative Committee on Aging, I am Herbert Weisberg, Chairman of the Legislative Forum of the South Carolina Federation for Older Americans. The SCFOA is a statewide organization representing members of various senior citizen groups as well as members of the general public concerned with the problems of the aging.

One advantage or disadvantage of being placed so far down on the list of speakers is that almost everything, if not everything, that I want to talk about has already been said by the previous speakers. However, I do want to touch on those matters of importance that the Legislative Forum ~~has~~ has determined to be our priorities for 1989-90. We are very appreciative of your efforts in the past and hope we can continue to work jointly in the future.

The priorities I wish to discuss are not listed in any specific order of need, but all are of concern to us;

To encourage at-home care of the frail elderly to enable them to remain in their homes rather than being institutionalized.

By giving a tax credit for families who provide for a frail elderly family member;

Developing adult day care services;

Developing programs through the State Housing Authority for innovative housing options such as "Granny Flats" already successful in Canada and Pennsylvania. These are 1-bedroom modules, something like a mobile home, which can be set up in the back yard of a house for an elderly member of the family. This will allow for independent living but close enough for some supervision by the family.

We are in favor of increasing the Homestead exemption from $20,000 to $25,000.

We advocate a program of Health Care Cost Containment as well as working toward Medicaid payment equality between South Carolina and other states.

We favor the passage of a Health Care Consent Law, a Durable Power of Attorney for Health Care This is in regard to decisions that can be made for health care between life and the living will. The South Carolina Bar is working on this matter.

We favor The Palmetto Gold Card for senior citizens at no charge.This should be a statewide program to give discounts to cardholders. Several of the local Councils on Aging have some sort of discount program in effect now.

We advocate a program of Home Equity Conversion. This means converting the equity in a home into cash, without having to move or make regular loan payments. HEC plans enable older homeowners to receive current income from their homes. The major types of HEC are reverse mortgages, sale leasebacks, property tax deferrals, and deferred payment loans. I will not attempt to cover allof these, but only the Reverse Mortgages:

> Reverse Mortgages (RMs) proved monthly loan advances up to 60 to 80% of the value of a home to a borrower. These advances do not have to be repaid (Principal or interest) until a future time. There are two kinds of RMs, fixed-term and open -ended.
>
> Fixed-Term RMs make monthly loan advances for an agreed-upon number of years (usually more than three but less than ten). Then the full amount of the loan must be repaid. Fixed-term reverse mortgages are currently available in Boston, Tucson, Minneapolis-St. Paul, Nassau and Suffolk Counties, NY., Bergen County, NJ, Milwaukee and Madison Wisconsin, most parts of California and throughout Connecticut and Rhode Island.
>
> Open-ended RMs make monthly loan advances for as long as the borrower lives in the home. This type of RM is commercially available in New Jersey, Maryland, Connecticut, Pennsylvania and Ohio.

We are in favor of the Medicaid Spousal Impoverishment provision of the Catastrophic Health Care Law but with that program being such a state of flux, this provision may be eliminated. However, we feel that there is a need for a State law to take effect even in spite of the Federal Law.

Thank you very much for the opportunity given to us to express our concerns to you.

Blackwell - **Thank you, sir, for a well reasoned presentation and you hurry now and don't let them write that ticket. Now we call on a gentleman I have a great deal of respect for Dr. Charles Still with SC Registry.**

PUBLIC HEARING BY THE JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

SEPTEMBER 20, 1989

Dr. Charles Still, Medical Director
USC-School of Public Health
Room 202
Columbia, SC 29208

TESTIMONY

OF

CHARLES N. STILL, MD

MEDICAL DIRECTOR, SC REGISTRY FOR DEMENTING ILLNESSESS

DEPARTMENT OF EPIDEMIOLOGY AND BIOSTATISTICS

SCHOOL OF PUBLIC HEALTH

UNIVERSITY OF SOUTH CAROLINA

Mr. Chairman, honorable members of the Committee, ladies and gentlemen - I am indeed grateful for the privilege of addressing the important issue of dementing illnesses in South Carolina. In my last appearance before this Committee in October 1985, I noted that the risk for Alzheimer's Disease increases with age, from about 5% at age 65 to more than 20% at age 80. Women are at greater risk at all ages. I also pointed out that Alzheimer's Disease is making a major contribution to the dramatic increases in health care costs in the United States. In 1979, Dr. Fred Plumm estimated the annual health care costs of dementing illnesses at $12 billion with a projected rise to $30 billion by the year 2030. Today the projected costs are estimated at more than $750 billion in the year 2030. This figure not only represents a 25-fold increase based on today's dollars, but also threatens to bankrupt the American taxpayer if more cost-effective health care does not become available by the year 2000. The head of the National Institute on Aging, Dr. Frank Williams, believes that scientific research should result in advances which will halt the

progression of Alzheimer's Disease by the year 2000. However, not many of the experts are this optimistic. They point out that until now the Congress has not been willing to spend more than $127 million annually for Alzheimer's Disease research. Currently the Congress recommends $300 million for research on Alzheimer's Disease, beginning October 1, 1989. This appears to be a generous increase. However, Congress has been spending over a billion dollars a year on AIDS research. During fiscal year 1990 Congress has recommended an increase to $1,306,000,000 for AIDS research. This increase exceeds the total for Alzheimer's Disease research. Despite the vigorous lobbying efforts of the National Alzheimer's Association, it appears that research on Alzheimer's Disease still has a low priority in Washington.

Perhaps the most intensive research effort on Alzheimer's Disease has been carried out by 20 centers known as CERAD, working from 1986 to 1989. These 20 centers have cooperatively studied about 530 cases and 364 control subjects using experts in clinical neurology, psychiatry, neuropsychology and neuropathology. Brain autopsies on more than 100 cases have shown that 83% have Alzheimer's Disease and another 10% have probable or possible Alzheimer's Disease. Stroke related dementias account for fewer than 3% of the cases. There is co-existent Parkinson's Disease in over 46% of the cases. This suggests that a common mechanism is at work. Such a mechanism may involve the passage of toxic substances across the blood-brain barrier over a period of many years. Aluminum remains one of the leading candidates for such a role in Alzheimer's Disease. Potentially protective effects of fluorides in drinking water have been studied

only in South Carolina. These showed a possible protective effect in the coastal regions where fluoride concentrations approached 4 parts per million in drinking water. However, the Environmental Protection Agency has required that high fluoride concentrations in drinking water be reduced to less than 2 parts per million, in order to prevent mottling of tooth enamel in children. This governmental action has probably reduced or eliminated the potentially protective effect of fluorides in drinking water against the potential toxicity of aluminum, which may be involved in the development of Alzheimer's Disease in late life. Otherwise, we have no known treatments or preventive measures which have been uneqivocally shown to halt or to slow the progression of Alzheimer's Disease.

In the meantime, what can we do about Alzheimer's Disease? The most comprehensive study of Alzheimer's Disease in this state was authorized by the Joint Legislative Health Care Planning and Oversight Committee and prepared by Dr. David Murday and colleagues in 1986. This bench-mark study recommended: 1) Epidemiologic research to help establish a firm data base to help estimate the incidence, prevalence, prognosis, and associated cost of Alzheimer's Disease and related disorders; and 2) that the General Assembly should establish a confidential Alzheimer's Disease reporting system through the Department of Health and Environmental Control for purposes of both research and planning.

With regard to the first recommendation, Dementia Registries (data bases) are extremely important for planning allocation of resources to meet future needs of victims of Alzheimer's Disease and their

families. Thus far Alzheimer's Disease appears to be most closely associated with increasing age, but a recent study in East Boston suggests that lack of formal education may also be a major risk factor. If so, the limited educational opportunities available to South Carolinans during the earlier years of the 20th century could bring far worse consequences than lost opportunities.

Yet against this stark background there is hope. Thanks to the initiative generated by the University of South Carolina School of Public Health, the South Carolina Registry for Dementing Illnesses was established in April 1988. The School of Public Health has recieved a generous award from the American Health Assistance Foundation, supplemented by matching funds from the South Carolina Health and Human Services Finance Commission, the Association of Schools of Public Health, and the Centers for Disease Control. The Registry is now housed in the Health Sciences Building of the School of Public Health at the University of South Carolina. The overall goal of the registry is to collect and report on the prevalence of dementing illness in South Carolina by type, age, sex, race, education, and other demographic characteristics.

Between the years 1980 and 2000 the percentage of South Carolina's population over 65 is projected to increase by 76%. By then, South Carolina may have as many as 50,000 citizens with Alzheimer's Disease. Since persons with this disease may live an average of 7 to 10 years from the beginning of symptoms until total care is needed, the potential cost continues to escalate. It is vitally important to identify those patients and their families who are now carrying the burden of Alzheimer's Disease in our state.

The South Carolina Registry for Dementing Illnesses has the potential to contribute unique information on the epidemiology of dementia in the United States. South Carolina has a racially mixed population (35% black) and one of the highest rates of stroke in the nation, especially among blacks. The rates of illiteracy are also high, approaching 50%, making the clinical diagnosis of dementia more difficult, since the interpretation of commonly used tests depends upon reading ability. About 40% of all cases of Alzheimer's Disease are genetic, and 60% are sporadic (of which some fraction may be transmissible). Familial Alzheimer's Disease is of critical importance to the public health of South Carolina's citizens.

The time is now right for the General Assembly to consider establishing a confidential Alzheimer's Disease reporting system through the Department of Health and Environmental Control, as recommended to the Joint Legislative Health Care Planning and Oversight Committee in December 1986. The South Carolina Registry for Dementing Illnesses and the University of South Carolina School of Public Health stand ready to cooperate and to support implementation of this recommendation for purposes of both planning and research. Working together with other public and private agencies and institutions under the guidance of the General Assembly, we echo the motto of South Carolina: "While I breathe, I hope".

Blackwell - **Thank you very much, Dr. Still. We will certainly take your advice under advisement. We appreciate your good work.**

Waldrop - **Didn't we put some money in for that? Didn't we fund that an amount we could get by on?**

Barron - **The registry is operating but we don't require reporting.**

Blackwell - **Thank you, Dr. Still. Now we have Rev. William Hankerson, Foster Grandparent, Retired Senior Volunteer Program.**

Rev. William Hankerson
Foster Grandparent
c/o Susan Carlton
Suite 207
240 Stoneridge Drive
Columbia, SC 29210

JOINT LEGISLATIVE STUDY COMMITTEE ON AGING

Wednesday, Sept. 20, 1989

My name is William Hankerson and I am a volunteer with the Foster Grandparent program here in the central part of South Carolina. Our program is sponsored by the Council on Aging of the Midlands.

I am one of 61 people serving as Foster Grandparents here. We each give 20 hours a week to help children and young folk that have a special need for attention and love. That's about 60,000 hours of loving kindness to more than 600 kids a year. We volunteer at 17 different places in Richland and Lexington Counties, such as the Department of Youth Services, Midlands Center, Sistercare, the Wil Lou Gray Opportunity School, Northside Middle School, Arden Elementary School and Headstart.

I've been a Foster Grandparent for 8 years. At first I worked at Midlands Center with retarded children. Working with those children is what made me love the program. You see this is kind of a dual thing - we help them and they help us. I treasure this work and this chance to be serviceable at my age. Here I am 70 years old and I didn't know the need for this work before.

Retarded kids know if you're real. You can't be a hypocrite or they'll feel it. Even if they can't talk, you find ways to communicate and they know if you really care about them.

Now the kids at the Opportunity School know it too, but they're tougher and try to manipulate you more. I've been there 4 years and I work in the RIP dorm. This is for the kids who break the Opportunity School rules. Keep in mind that all the kids at the school are there because they've broken rules or couldn't make it in their schools at home. In RIP dorm we get most of the kids some time or another during the school year.

Four evenings a week I spend five hours talking to them quietly, holding a mirror to their faces so they'll see themselves and try to improve their behavior. They call me "Pop" and, you know, they treat me with respect. They'll swear at each other and at their teachers, but not at me! And they ask me to say a good word for them so they won't get kicked out of the school. I stay in the office a lot of the time, talking to get them a second chance to stay and graduate. I've got 3 now at Benedict and one in the army that did make it. That makes me proud! And they were ones

I had to [illegible] to the office for. Maybe I had a little part in them maki[illegible] it this far.

You don't get too many that go to college. I wish it was so that you could save them all. But if I turn even one child around I'll feel good. And for us Grandparents, feeling good about our kids is what keeps us going.

Now I know you want your voters to feel good. But I also know that you think of this in bigger terms and in money terms, so let me put it this way: While I am working with each of these children at the Opportunity school I am stretching the dollars the state spends there and this is true of the Grandparents at Midlands Center and Youth Services and in the 8 public schools where we work.

If I help to turn just one kid around, the state saves hundreds of thousands of dollars that might have been spent on him for the rest of his life in the department of corrections or in food stamps, medicaid, and welfare. And this is true of every grandparent - even those that work with Headstart and Sistercare and other agencies that are not state agencies.

And us Grandparents: if just one or two of us keep on living active lives because of this program, instead of going downhill and having to go into nursing homes, that saves the state $32,000 a year for each one!

It costs about $3,000 a year for each Grandparent - to pay the stipend and travel that makes it possible for us to volunteer. For $15,000 from the state, for example, our program could add five grandparents and help 10 or 20 more kids. When our director comes and asks you how to get state funds, I hope you'll help her because I'm sure you can see how much you can save later by investing a little now.

Let me hold a mirror up to your faces like I do with my kids. Do you see a person who cares if a kid is turned around? Do you see one who wants older folks to be useful? If we laymen can see how much this is needed, I know you will see it too. Thank you.

Blackwell - **Thank you, Mr. Hankerson. We appreciate the service you do for the children. Now I don't see Pat here yet. So we will pass on to Jo Ann Price from DHEC**

(38)

SOUTH CAROLINA
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
PEE DEE DISTRICT I

DILLON COUNTY DIVISION
1st Ave. and Hampton
P.O. Box 1064
Dillon, S.C. 29536
Phone 774-5611

FLORENCE COUNTY DIVISION
P.O. Box 3499, 1705 W. Evans
Florence, S.C. 29502
Phone 662-5281

MARION COUNTY DIVISION
P.O. Box 609, Hwy. 76
Marion, S.C. 29571
Phone 423-4312

JoAnn Price, Director
DHEC
1550 W. Evans St.
Florence, SC 29501

Mailing Address
1550 W. Evans Street
Florence, S.C. 29501

Phone 669-4317

Testimony to

Joint Legislative Committee on Aging

Jo Ann Price, RN, Director
Nursing Services
SCDHEC - Pee Dee I
1550 W. Evans St.
Florence, SC 29501
(803) 669-4348

Problem:

Individuals being served under the End Stage Renal Disease (ESRD) program in S.C. are not able to receive necessary home health care because of federal guidelines pertaining to payment for home care. The federal guidelines state that patients with ESRD must receive all renal related services by the dialysis center. In S.C. this is most often interpreted to mean that any problem a dialysis patient has is renal related. The effect of this "mind set" on the part of the intermediary (Blue Cross/Blue Shield) severely restricts the availability of home care to dialysis patients. Unless a dialysis patient develops an illness or sustains an injury that cannot remotely be associated with their kidneys and their function, they are denied payment for home health care.

Because the management of ESRD has become so sophisticated we are seeing more and more patients living longer and needing nursing care of a highly technical nature. Many of these services can be provided in the home. Due to increasing health care costs hospitals are discharging patients for care in the home. Because these patients are not getting their care paid for in the home they are being kept in the hospital longer thus increasing cost or being discharged home where they receive no care.

I request from this committee that you explore with the Department of Health and Human Services, the Health Care Financing Commission and the S.C. intermediary (BC/BS) the possibility of major changes for the funding of home care for S.C. ESRD patients.

Suggested recommendations are:

(1) that these agencies recognize that ESRD patients need more services than current ESRD facilities can or will provide i.e. home care.

(2) that consideration be given to changing funding for Home Health care such that a portion of medicare funds are no longer provided to the dialysis center with the expectations that they provide home care and that these funds be held for reimbursement of home health agencies whose expertise and priority is care of the patient in their home.

In conclusion, I recognize this is a federal issue but I ask you as our State leaders to keep this need before our S.C. federal representatives in Washington.

Letters on file with Committee transcript:

1) Letter to Mr. Donald O. Morillo, Staff Assistant for Congressman Arthur Ravenel, Jr. from Jackie L. McGee, MSW on August 9, 1989

2) Letter to Ms. Jackie L. McGee, V.A. Medical Center, from Congressman Arthur Ravenel on August 31, 1989

3) Letter to Congressman Arthur Ravenel from Vicky S. Fields, R.N., Provider Education Consultant on August 28, 1989

4) Letter to Florence Dialysis Clinic from Deloris G. Griffith, Director of the Division of Home Health Services on August 31, 1988

5) Letter to Felicia Smith, Florence Dialysis Center, from Jo Ann Price, District Nursing Director on June 2, 1989

6) Letter to Dr. Foster H. Young, Jr., District Medical Director, from Deloris G. Griffith on April 5, 1989

7) Letter to ESRD Facilities from Medicare Part A Provider Services on April 1988

Blackwell - Thank you, Miss Price. It sounds like we are going to have alot to tell the Federal folks and we appreciate you calling this to our attention. We are asked to hear from Judy Allen, Customer Service Supervisor from our brand new division of Insurance Services. Is Miss Allen here or a representative? Is there anyone else who needs to be heard by this Committee? Anyone else?

Barron - Miss Cline was recognized earlier but was not here. She is here now.

Blackwell - Miss Shirley Cline is here and we are glad she is here. Allright. Did you need to make a statement? We are glad you are here. The Committee will be adjourned in a moment and we will ask staff to prepare the proper materials and then we will be subject to recall by our Chairman in order to make some decisions about what legislation we are to recommend.

With no other business, the Committee stands adjourned.

SEP 19 1989

STATE OF SOUTH CAROLINA

State Budget and Control Board

DIVISION OF INSURANCE SERVICES

Judy Allen
Customer Service Supervisor
B&C Board - Div. of Insurance Servi
P.O. Box 11661
Columbia, SC 29201

HEALTH INSURANCE SERVICES
POST OFFICE BOX 11960
1122 LADY STREET
COLUMBIA, SOUTH CAROLINA 29201
(803) 734-1660

September 15, 1989

The Honorable Patrick Harris
Chairman, Joint Leg. Committee on Aging
212 Blatt Building
Columbia, SC 29211

Dear Rep. Harris:

Per request from your office, following are the details regarding open enrollment for retirees:

1. Open Enrollment begins October 1 and lasts until October 31, 1989.

2. Open enrollment meetings will be held throughout South Carolina October 16 through November 2, 1989.

3. Each retiree will be required to complete a new Notice of Election form before October 31, 1989. An NOE will be mailed to each retiree presently enrolled in the program by October 5, 1989, and NOE's will be available at all open enrollment meetings.

4. A toll free number will be provided for retirees throughout this enrollment period. That number is 1-800-868-3672 or you may call 734-0612 in Columbia.

5. Retirees may come to our office for assistance, 6th floor, NBSC Bank Building, corner of Lady and Main, Columbia.

6. Long Term Care enrollment is scheduled for late fall 1990.

If I can be of further help, please let me know. We would be honored to attend your meeting on September 21, 1989, if you desire.

Sincerely,

Judy Allen

Judy Allen
Supervisor, Customer Services

cc: Jim Davis
David Anderson

Albert Sedlacek
161 Spanish Point Drive
Beaufort, SC 29902

161 Spanish Point Drive
Beaufort, S. C. 29902

August 9, 1989

Hon. Keller H. Barron
Joint Legislative Committee on Aging
Blatt Building
Columbia, SC 29211

Dear Ms. Barron:

I understand that a hearing by the Joint Legislative Committee on aging is scheduled for September 20, 1989 and you have requested comments from the public.

The recent decision by the State of South Carolina to tax state pensions and use the revenue to increase benefits for those retirees does not address the issue of South Carolina residents receiving retiree benefits from other states.

The instructions for filing my 1988 South Carolina tax return referred to line 43 and stated: "South Carolina has a reciprocal agreement with some states on exclusion of part or all of state employees' and school teachers' retirement income. You may subtract the excludable portion from your income."

Enclosed is a copy of my letter written to Sen. James M. Waddell, Jr., dated July 10, 1989, to which I have not yet received an answer.

I do not understand how South Carolina can unilaterally tax a pension from another state with which it has a reciprocal agreement of non-taxation.

Your help in putting this matter before the committee would be appreciated.

Respectfully yours,

albert j sedlacek

Albert J. Sedlacek

cc: Sen. James W. Waddell, Jr.
Rep. Harriett Keyserling

RETIREMENT BENEFITS
PUBLIC SCHOOL TEACHERS AND STATE EMPLOYEES

State	Reciprocal Agreement	No Reciprocal Agreement	Exclusion of Retirement Income	Retirement Benefits Not Taxed
Alabama		X		
Alaska				X
Arizona		X		
Arkansas			X(1)	
California		X		
Colorado			X(2)	
Connecticut				X
Delaware			X(3)	
District of Columbia		X		
Florida				X
Georgia	X(4)			
Hawaii				X
Idaho		X		
Illinois	X			
Indiana		X		
Iowa		X		
Kansas		X		
Kentucky		X		
Louisiana			X(5)	
Maine		X		
Maryland			X(6)	
Massachusetts				X
Michigan	X			
Minnesota				X
Mississippi			X(7)	
Missouri		X		
Montana		X		
Nebraska		X		
Nevada				X
New Hampshire				X
New Jersey			X(8)	
New Mexico		X		
New York			X(9)	
North Carolina	X			
North Dakota			X(10)	
Ohio			X(11)	
Oklahoma		X		
Oregon		X		
Pennsylvania				X
Rhode Island		X		
South Carolina				X
South Dakota				X

3/3/89

Tennessee			X
Texas			X
Utah			X(12)
Vermont	X		
Virginia			X(13)
Washington			X
West Virginia	X		
Wisconsin	X		
Wyoming			X

FOOTNOTE:

(1) Retirement income exclusion up to $6,000.
(2) Retirement income exclusion up to $20,000 per year per taxpayer.
(3) Retirement income exclusion up to $2,000.
(4) Reciprocal agreement for public school teachers and not state employees.
(5) Retirement income, over 65, exclusion up to $6,000; both over 65, up to $12,000 exclusion.
(6) Retirement income, over 65, exclusion up to $9,500.
(7) Retirement income exclusion up to $5,000.
(8) Retirement income exclusion $10,000 for married couples filing jointly; filing separately, retirement income exclusion $5,000; filing single return, retirement income exclusion $7,500. To qualify for retirement income exclusion, taxpayer must be disabled or age 62 or over.
(9) Retirement income exclusion up to $20,000 if taxpayer is 59 1/2 or older.
(10) Retirement income exclusion up to $5,000 reduced by social security benefits.
(11) A credit is allowed as follows: If retirement income is:

	Tax Credit
Less than $500	-0-
$500 but less than $1,500	$ 25
$1,500 but less than $3,000	$ 50
$3,000 but less than $5,000	$ 80
$5,000 but less than $8,000	$130
$8,000 or more	$200

(12) Retirement income exclusion up to $4,500, over 65, up to $6,000 excluded.
(13) Retirement income exclusion $2,000, over 65 up to $8,000 excluded.

NOTE: If retirement income is subject to tax after above exclusion and retired taxpayer is 65 or over, the South Carolina retirement exclusion of up to $3000 may also be deducted.

3/3/89

Lewis Levy
SC State Housing Authority
1710 Gervais St.
Columbia, SC 29201

SOUTH CAROLINA STATE HOUSING FINANCE AND DEVELOPMENT AUTHORITY

1710 GERVAIS STREET, SUITE 300, COLUMBIA, SOUTH CAROLINA 29201

June 29, 1989

Keller H. Barron, Director of Research
Joint Legislative Committee on Aging
Post Office Box 11867
Columbia, South Carolina 29211

Re: HUD Home Equity Conversion Mortgage Demonstration Program

Dear Keller:

Thank you for you call Wednesday about the hearing scheduled for September 20. The Authority's new Executive Director is E. Anthony Buzzetti. Either he, I or both of us will try to be available. There is a possible complication of which I have just been made aware. The annual meeting of the National Council of State Housing Agencies will be held in Oklahoma City September 17-19. No travel plans have been made yet, so I don't know if we will be back by the morning of the 20th. In the event that there is a problem, I will see that you have a written report as to the status of the HECM Demonstration. Of course, we hope it will be underweight by that time.

Enclosed is a copy of HUD's final rule for the program.* As you read through it you will see why some lenders are less than wildly enthusiastic. Fannie Mae's participation is essential to the success of this demonstration.

Thus far I have received 22 inquiries about the program. I don't think there will be any difficulty in using all 50 reservations.

We will be meeting with a private lender next Friday to discuss his participation. I will let you know how that meeting goes.

With my best regards.

Sincerely,

Lewis M. Levy
General Counsel

LML/tr

On file with Committee Transcript
Department of Housing and Urban
Development 24 CFR Parts 200 & 206

Representative Thomas G. Keegan
32 West Sweetbriar Trail
Surfside Beach, SC 29575

House of Representatives

State of South Carolina

Thomas G. Keegan
District No. 106 - Horry County
32 West Sweetbriar Trail
Surfside Beach, S.C. 29575

Committee:
Education and Public Works

August 10, 1989

434-D Blatt Building
Columbia, S.C. 29211

Tel. (803) 734-3069

COPY

PRT

Mr. David Burgis
Manager, Office of Tourism Investment
Division of Engineering & Planning
Columbia, SC 29201

Dear Mr. Burgis:

Thank you very much for your kind comments in your letter of July 21, 1989 in which you refer to remarks made by me as quoted in The Coastal Observer.

The information you provided regarding attracting retirees supports what I have been saying all along. I am absolutely convinced that we can compete with Florida and other sunbelt states and convince retirees that South Carolina is the place to be.

My figures indicate that between 1983 and 1987 the state of Florida attracted 15,000 retirees while South Carolina was only able to convince 3,000 retirees to move here. Our state certainly has the climate, amenities, reasonable housing, cultural and recreational standards, adequate medical facilities and favorable crime statistics.

A more favorable economic climate in Florida is obviously a major reason retirees choose that state. I think it is incumbent upon all of us to do whatever we can to encourage retirees to move here and, for that purpose, I have introduced House Bill #3886 which will repeal the estate tax. House Bill #3381 and Senate Bill #116 attempts to raise the state retiree income tax exemption from $3,000 to $6,000.

Rec. 8-17-89

The support of the Joint Legislative Committee on Aging, PRT, Chamber of Commerce and other appropriate bodies would greatly enhance our efforts to increase the attractiveness of our state.

I have enclosed a copy of Bill #3886 and an article which appeared in the Sun News.

I look forward to your support and welcome the opportunity to work with you on this important project.

Very truly yours,

Thomas G. Keegan

REPRESENTATIVE Thomas G. Keegan
House District 106

cc: Honorable Carroll Campbell
Governor of State of S.C.

cc: Honorable Pat Harris
SC House of Representatives

cc: Mr. Russell Munn
S.C. Chamber of Commerce

JERRY C. AUSBAND / *Editorial page editor*

Seeking the retired

State Rep. Tom Keegan paints a lovely picture of a retirement community.

It has brilliant hues of affluence and influence; it mixes in earth tones of not costing the community much in services or infrastructure; it blends in subtle strokes of new blood.

It's pretty, but will it sell?

Keegan, a Republican first-termer who represents the southeastern part of Horry County, wants South Carolina "to consider everything it can to attract retirees to this state."

"From a purely business standpoint," Keegan argues, "retirees are the best industry we could have in this state."

As a young retiree himself, Keegan is trying to do something to spur retirement growth in the state.

He won election at least partially on his promise to try to increase the homestead exemption on primary residences for people more than 65 years old. According to the message he gave the Garden City Community Association last week, his efforts have so far succeeded but could fail in the end.

The state appropriations bill, headed for a conference committee of House and Senate members, contains an exemption increase to $25,000, up from $20,000. That would help bring retirees here, as well as aid those already arrived from other locales and those retired here after never living anywhere else.

Keegan's "guesstimate" is that the exemption increase — at a cost of $7 million to the state, which rebates exemptions to local governments — will not survive spending pressures, not this year at least.

As a further means of enticing more than the 20,000 who retire in South Carolina annually, Keegan has introduced a bill that would repeal estate taxes. He has no hope the repeal will occur this year; it's too late in the legislative year; and the bill is not out of committee. But next year, expect a battle over the issue.

And Keegan seems to eye an assault on the state income tax, but he has no stated plans yet to introduce repeal. If South Carolina had neither estate taxes nor income taxes, benefits here would match those in Florida. That state gets 10 times as many new retirees each year as South Carolina.

All that sounds grand.

Retirees tend to be the best, most dedicated readers of The Sun News, my own informal, unofficial survey shows. Retirees tend to be more consistent voters than the general population and may be more politically activist as well. Often, although not consistently, retirees who move here tend to be more affluent. Retirees tend to increase the area's level of education and savvy.

Remember, retirees do not necessarily equate to elderly. At least insofar as the military is concerned, a 20-year retiree could be as young as 38, ready to go into a second career. Retirees from private business are not usually quite so young, but, more and more, retirees are not just those who have reached age 65.

Current retiree statistics are hard to come by, but suffice it to say retirees are a growing number amid all the demographics of the area. It is easier to track age groups than numbers of retirees. However, two results of a new study of tourist marketing for the Myrtle Beach Area Chamber of Commerce are illuminating:

- The average age of the chief wage earner among Grand Strand visitors is 48.
- About 22 percent of visitors classify themselves as retired.

Maybe, then, Keegan is on to something. However, just getting retirees here isn't enough. Long-range planning must take into account the aging process and its medical needs, for instance.

The picture Keegan is painting looks real nice, but could it require more depth before putting it on the market?

Eve Stacey
SC Bar
950 Taylor St.
Columbia, SC 29201

Health Care Consent Law Reform Project

South Carolina Bar
Hospital and Health Law Committee
in Cooperation with the
South Carolina Commission on Aging

We are very pleased to report that our study of problems encountered in determining who can and should speak on behalf of an incompetent patient concerning health care treatment, is progressing very well. The proposed study project was brought to the attention of the Hospital and Health Law Committee of the South Carolina Bar by the South Carolina Commission on Aging's Advisory Committee on Legal Advocacy for the Elderly.

Members of the Advisory Committee representing South Carolina Department of Social Services and the State Long Term Care Ombudsman noted the need for a mechanism for obtaining consent for health care for the incompetent patient. This is a problem most prevalent among indigent elderly patients. The Ombudsman's Office related an incident in which an elderly patient in a facility fell and broke her hip. She was unable to sign a consent for treatment, and her physician refused to operate until her condition became life threatening; five days passed in the interim. While this example may seem extreme, this apparently is not an isolated sort of incident.

The normal procedure in this type of situation is for the Department of Social Services to petition the probate court for the appointment of a Guardian. This procedure is frequently considered to be both costly and time-consuming.

The Advisory Committee on Legal Advocacy for the Elderly identified some possible legislative solutions to some of the problems, but concluded that there are a number of ethical and legal issues which must be considered before any legislation can be enacted. The Hospital and Health Law Committee of the South Carolina Bar was approached for input. A mini-grant was obtained from the American Bar Association Commission on Legal Problems of the Elderly to determine what other states have done, and to see how hospitals, nursing homes, and individuals in South Carolina deal with issues in the area of consent.

Professor Elizabeth G. Patterson of the University of South Carolina School of Law agreed to donate a great deal of her time for research and drafting. In April, there was a meeting of the leaders/heads of agencies, associations and other interested groups to discuss the project. Most were very interested in what we are doing and in what proposals will result from the study.

Surveys of nursing homes and hospitals were sent out in July. We worked closely with the South Carolina Hospital Association developing the surveys, and response was good.

During July, four community forums were held around the state to elicit information from individuals who are familiar with health care consent problems concerning family, friends or acquaintances in hospitals or nursing homes. The purpose of these meetings was to gain insight from the individual, as opposed to the institutional point of view. We received a great deal of valuable feedback from those in attendance.

Another meeting with the agency and association leaders is scheduled for October 2 to review the information that we have compiled to this point. Decisions will be made as to which of the identified problems we can address and how. We expect to begin drafting proposed legislation to address problems shortly thereafter. When there are draft proposals to present, there will be another meeting of the agency and association leaders to review the proposals, and make any necessary changes. It is anticipated that such a meeting will take place in early November.

Every effort will be made to reach a consensus of support for the work product of the project from the various agencies, associations and interest groups who have been involved in the project. It is not anticipated that the recommendations which result from this project will be a panacea, however, it is hoped that some of the problems which were identified both before and during this study can be addressed, and some solutions proposed.

Respectfully submitted,

Eve Moredock Stacey

Eve Moredock Stacey
Public Services Director
South Carolina Bar

September 20, 1989

R. Linwood Altman
District No. 108 - Georgetown County
Box 164
Pawleys Island, S.C. 29585

434-C Blatt Building
Columbia, S.C. 29211

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House of Representatives

State of South Carolina

Representative R. Linwood Altman
P.O. Box 164
Pawleys Island, SC 29585

Committees:
Education and Public Works†
Highways Sub-Committee††
Interstate Cooperation†
State Bidding Procedures†
Procurement Policy Committee†
Joint Committee on Highways
†1st Vice-Chairman ††Chairman

Boards and Commissions:
South Carolina Coastal Council
South Carolina Highway Commission
College of Charleston, Trustee

August 31, 1989

The Honorable Patrick B. Harris
Box 655
Anderson, SC 29621

Dear Pat:

I have been advised that the committee you chair on the Study Services, Programs and Facilities for Aging will have a hearing on S-578 and H-3594 (Mobile and Modular Home Park Tenancy Act) on September 20th.

I am pleased to have a number of well developed parks in my district that have been "home" status with amenities and extensive landscaping. Many of these people are retirees who are making coastal South Carolina their home.

A number of these have expressed their concerns to me about some wording in the Landlord and Tenants Act and are especially interested in asking for some amendments to S-578 and H-3594.

Many of these parks have become retirement villages with some of the finest folks I know and their concerns center around the very things we are all concerned about, however, they feel that there is a certain vulnerability due to the nature of their homesites.

I would ask that your committee give special attention to a provision for extension of leases, lease cost esculation, relocation in case property is sold for other purposes and option of lease renewals.

Recently one park in my district was sold and this resulted in an immediate 35% increase in lease and a reduction in amenities with no line of communication to the new owner. This is not condusive to the well being of people on fixed income.

I will greatly appreciate any assistance your committee will provide to these people; knowing all members of your committee well, I feel that it could be in no better hands.

With all best wishes.

Sincerely,

R. Linwood Altman

cc: Committee members
enclosre: Florida statutes

RLA/bwa

JOINT LEGISLATIVE COMMITTEE ON AGING

Public Hearing Schedule

Blatt Building, Room 101

Wednesday, September 20, 1989

10:30-11:30

10:30-10:35 Representative Patrick B. Harris, Chairman
Welcome and Opening Remarks

10:35-10:50 Helen Brawley, Chair
Ollie Johnson, Executive Assistant
SC Commission on Aging

Miriam E. Patterson, Legilative Committee
Council on Elder Affairs

10:50-11:00 Connie Shade, President
SC Association of Area Agencies on Aging

11:00-11:10 Mildred McDuffie, Commissioner
SC Commission on Women

11:10-11:20 Steven W. Hamm, Administrator
SC Department of Consumer Affairs

11:20-11:30 Fletcher Spigner, Executive Director
Council on Aging of the Midlands

11:30-12:30

11:30-11:40 Dr. Richard Cowling, Chair
SC Nurses' Association

Denise Wiles, Program Director
Elderly Assistance Line

11:40-11:50 Samuel T. Waldrep, President
SC Gerontology Society

11:50-12:00 Kenneth White, State Legislative Chairman
American Association of Retired Persons

12:00-12:10 Tim Cash, Adult Services Division Director
SC Department of Social Services

Len Marini, Director of Research
Joint Legislative Committee on Cultural Affairs

12:10-12:20 James R. Rider, Horry County Citizen

12:20-12:30 Dr. James I. Califf, Executive Director
Horry County Council on Aging, Inc.

12:30-1:30 LUNCH

1:30-2:30

1:30-1:40 Gwen Power, Deputy Executive Director
State Health & Human Services Finance Commission

1:40-1:50 Jim Manning, Chair, Educ. Legislation Action Network
Dolores Macey, Health Issues Task Force
Pat Harmon, Health Issues Task Force
SC National Association of Social Workers

1:50-2:00 Margaret L. Baptiste, President
Walter Reed, Legislative Chair
SC Federation of Chapters - National Assoc.
of Retired Federal Employees

2:00-2:10 Col. Angelo Perri, Vice-President
SC Council of Chapters of the
Retired Officers Association

2:10-2:20 Eric Bouchard, Vice-President
Providence Hospital

2:20-2:30 Eleanor Conway, R.N., Director
E & E Personal Care Agency, Inc.

2:30-3:30

2:30-2:40 Jerome Noble, Director
Division of Public Transportation
SC Department of Highways & Transportation

2:40-2:50 Mary Gail Douglas, President
SC Association of Council on Aging Directors

2:50-3:00 Lisa Richter-Moss, Social Service Consultant
Spartanburg County

Carol Reis, Executive Director
Finlay House

3:00-3:10 Dr. Daniel Brake, President
SC Medical Association

3:10-3:20 Dr. Michael Stogner, Aging Unit Director
SC Appalachian Council of Governments

3:20-3:30 Tim Harbeson, Legal Division
Governor's Office, Division of Ombudsman
and Citizen Services

3:30-4:30

3:30-3:40 Mary A. Mace, President
Elaine Marks, Legislative Chair
SC Retired Educators Association

3:40-3:50 Preston H. Callison, General Counsel
SC Hospital Association

3:50-4:00 Herbert Weisberg, Chairman
Legislative Forum
SC Federation of Older Americans

4:00-4:10 Dr. Charles Still, Medical Director
SC Registry for Dementing Illnesses

4:10-4:20 Rev. William Hankerson
Foster Grandparent, Retired Senior Volunteer Program

4:20-4:30 Patrick Mason, Executive Director
SC Retirement Communities Association

Jo Ann Price, District Nursing Director
DHEC - Florence, Dillon, Marion Counties

Judy Allen, Customer Service Supervisor
Divsion of Insurance Services, Budget & Control Board

Written Statements submitted by persons unable to attend:

Albert J. Sedlacek, Beaufort County Citizen
Reciprocal State Agreements Regarding Taxation of Retiree Income

Lewis M. Levy, General Counsel
SC State Housing Finance & Development Authority
HUD Home Equity Conversion Mortgage Demonstration Program

Representative Thomas G. Keegan, Horry County
Repeal of Estate Tax - H.3886
Increase State Retiree Income Tax Exemption - H.3381 & S.116

Eve Stacey, South Carolina Bar
Health Care Consent Study Project

Representative R. Linwood Altman
Mobile Home

/0238/